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ABSTRACT

A three-year home-teaching demonstration project with the geriatric blind was conducted with 171 clients in the experimental group (132 were blind for 10 years or less and were 60 years of age or older, 11 were blind 17 years or longer, 7 were in an apartment group, 7 died, and 14 had incomplete records) and 44 clients in the control group. The two teachers, both blind since childhood, held Master's Degrees in Special Education, Program for Training Home Teachers of the Adult Blind. Included among the most relevant findings of the project are the following: (1) clients 60 years of age or over and blind less than 10 years can learn various daily living skills through home teaching; (2) the client's attitudes toward life are linked with his ability to master skills; (3) the client's age was not important in the learning of skills; (4) in general, women were superior to men in skills and attitudes, and Negroes were superior to whites on all tests; (5) the 60 years of age or older blind client needs skilled help in improving their skills and attitudes; (6) generally, those clients who lived alone with no outside help scored highest in skill and attitude improvement; and (7) progress made in communication skills was impressive. Six case studies are given, and appendixes present the rating sheet, statistical summary, and project personnel biographies. (DB)

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HOME TEACHING OF THE GERIATRIC BLIND

By

Giles Edward Gobetz
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The Cleveland Society for the Blind
1969

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Final Research Report (AA-4-66-003)
to the Administration on Aging of the
U. S. Department of Health, Education and Welfare

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1969

FOREWORD

Among the many activities which are going on at the Cleveland Society for the Blind -- last year nearly 2,000 clients were served -- the Home Teaching of the Newly Blind Geriatric Clients seemed to evoke some special "out-of-town" interest. After the first progress reports had gone out to the U.S. Administration on Aging, and a few copies to other agencies and individuals, the Cleveland Society for the Blind received an exceptionally large number of requests for subsequent copies of progress reports and, especially, for the final research report. These requests, together with some very flattering comments, came from many parts of the United States and even from abroad.

We are very happy today to be able to present this final research report -- a publication which we hope you will find interesting, informative and useful.

The Home Teaching of the Geriatric Blind reports the story and presents the evaluation of a three-year demonstration project which was co-sponsored by the U.S. Administration on Aging and the Cleveland Society for the Blind. The present publication represents perhaps the most comprehensive and intensive study of a single home teaching demonstration project with the geriatric blind so far in existence. It is the end product of many cooperative efforts: those between the U.S. Administration on Aging and the Cleveland Society for the Blind; those between project staff and volunteers and project clients; those between practitioners and researchers.

In presenting this final report, we certainly want to thank most warmly the U.S. Administration on Aging, without whose understanding and support our project would not have been possible. Our thanks also go to the two totally blind home teachers, Miss June Jenkins and Miss Suzanne Johnson, whose dedicated work is here described and evaluated, and to the unswerving authors who produced this publication. Last but not least, our gratitude goes to more than two hundred geriatric blind clients who, as members of experimental or control groups, became our most indispensable collaborators.

We hope you will enjoy this publication and, perhaps, derive some new useful understandings and inspirations from it. Your comments, suggestions and criticisms will, of course, always be welcome.

Cleo B. Dolan
Executive Director
The Cleveland Society for the Blind

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I. BACKGROUND INFORMATION

1. Blindness

Dictionaries and encyclopedias usually define blindness as sightlessness or lack or loss of sight. Specialists, however, need more precise definitions. They usually agree that blindness is "central visual acuity of 20/200 or less in the better eye, with correcting glasses; or central acuity of more than 20/200 if there is a field defect in which the peripheral field has contracted to such an extent that the widest diameter of visual field subtends an angular distance no greater than 20 degrees." This latter definition of blindness is most frequently used also by the Federal and State governments. In nontechnical terms it means that a person is legally blind if he can identify only at 20 feet what a person with normal vision can identify at 200 feet, or if his field of vision is so restricted that he can see only a very small area at a time.[1]

The estimated number of legally blind persons in the United States in 1960 was about 355,000. In addition, some 30,000 Americans lose sight each year. They are primarily in the highest age groups and often suffer additional physical, emotional, mental, social or economic handicaps.[2]

Thus, while blindness means the lack or loss of sight, it tends to be associated with many other losses. Reverend Thomas J. Carroll writes: "Loss of sight is a dying. ... However it comes, it is death to a way of life that had become part of the man. It is the end of acquired methods of doing things, the loss of built-up relationships with people, of ingrained relationships with environment."[3]

The same writer, in his analysis of what the blind man loses, discusses no fewer than twenty major losses: 1. the loss of physical integrity -- the newly blinded person is "maimed," "crippled," "afflicted"; 2. the loss of confidence in the remaining senses -- his sight used to confirm their accuracy before, but the newly blinded person no longer has such confirmation; 3. the loss of reality contact with environment, resulting in feelings of disorientation, Where am I? Who are you? What happened? 4. the loss of visual background -- lights and shadows, crowds and trees, constant changes which protect a sighted man from monotony and constitute "a form of recreation"; 5. the loss of light security -- light which is connected with ideas of truth, goodness and beauty; 6. the loss of mobility -- a return to the immobility or creeping dependence on others, the danger of walking across the street, the terror of traffic, or crowds or objects in one's way; 7. the loss of techniques of daily living -- eating, drinking, cooking, doing one's job, shaving, applying lipstick, checking one's appearance; etc.

The list of losses continues: 8. the loss of ease of written communication; 9. the loss of ease of spoken communication; 10. the loss of informational progress; 11. the loss of the visual perception of the pleasurable; 12. the loss of the visual perception of the beautiful; 13. the loss of recreation; 14. the loss of career, vocational goals, or job opportunities; 15. the frequent loss of financial security; 16. the loss of personal independence; 17. the loss of social adequacy; 18. the loss of obscurity (he "lives in a show window" and his "privacy dies"); 19. the frequent loss of self-esteem; and 20. the loss of total personality organization.[4]

As is the case with attitudes and behaviors in general, reactions of the blind and of the society in which they live have varied greatly from time to time and from place to place. Yet, Chevigny and Braverman compare the blind to a minority group, such as Jews or Negroes, and maintain that "historically there is much justification for the parallel. One notes the social ostracism, the creation of a class, the restriction to areas and sections. In both instances the phenomenon is one of a group of people whom the majority insists on endowing with special characteristics, for whom a stereotype has been evolved which each member of the minority is supposed to exemplify, and the essence of which is the imputation of inferiority."[5]

Although modern societies are making giant steps in overcoming such stereotypes and the image of the blind beggar or sweatshop worker is increasingly challenged by our awareness of blind technicians, salesmen, professors or authors, many ancient stereotypes persist even in modern societies.

The blind person today has to adjust to his loss or lack of sight and to his many other losses and handicaps amidst a partly ignorant and partly enlightened society.

The majority of the blind in America lose their sight after fifty, when adjustment is further complicated by age and other concomitant disabilities. According to Dr. Louis Cholden, a newly blinded person inevitably goes through a stage of shock followed by a second stage of grief or bereavement. At first, he realizes his inability to function or even to comprehend; then he goes through a period of mourning for the life that is gone.[6] But what comes after these two stages?

The blind represent all kinds of social backgrounds, possess all kinds of personalities, live in many different kinds of social environments, and, once the initial trauma is more or less overcome, adjust -- or fail to adjust -- to blindness in many different ways.

Blindness is a loss, accompanied with many other losses and handicaps. But it brings with it also the challenge of rehabilitation and restoration -- the challenge which must be intelligently and courageously faced by the blind individual and by the society in which he lives and in which he should continue to function with a reasonable degree of independence and happiness.

2. Home Teaching of the Blind

Home teaching was one of the earliest constructive responses to the challenge of rehabilitation and restoration of the blind. It has started with the services of friendly concerned helpers -- a relative, a visiting friend or a charitable volunteer -- who spontaneously tried to help the newly blinded persons by showing them their sympathy and concern and teaching them some of the most essential skills, such as finding their way around the house and its immediate surroundings; identifying various objects, including food, drinks, money and clothes; and performing simple tasks, such as making baskets or brooms, husking corn, etc. Thus, an early alternative to complete dependency, isolation or ostracism was established.

It is believed that this spontaneous home teaching was first organized and systematized into a regular service for the blind by Dr. William Moon and his collaborator John Rhodes when, in 1882, they established, in Philadelphia, Pennsylvania, a Home Teaching Society "in order that the adult blind might read the Bible and other religious literature, receiving therefrom spiritual light and guidance."[7]

Since then, home teachers have participated in the rehabilitation of thousands of blind persons and have made professional progress in a number of ways.[8]

Yet, until recently, the home teacher has not achieved full professional recognition. He "has been called upon to perform as the all-around utility man."[9] His status among the professionals has not only been low but also ambiguous. Raymond M. Dickinson made a survey of agencies throughout the country which employed home teachers -- or said they did -- and collected twenty-two different definitions of home teaching. "One

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correspondent said that the home teacher should teach anything the client wanted to learn -- a big order in our times. !"[10]

Leading experts themselves disagreed on the proper role and status of home teachers. Gilmartin, for instance, considered home teaching a specialty of social work,[11] while Forward put an emphasis on teaching, thus making it a branch of special education.[12]

Since the goal of a client's maximum possible rehabilitation and restoration is shared by social workers and home teachers alike, since the development of specialization in both areas was slow and gradual while pressing needs led to constant overlapping of functions, and since many aspects of either role (sympathetic understanding, personal warmth, etc.) should probably never be divorced from either specialty, the difficulty in reaching a unanimous consensus on the delineation of respective roles is understandable.

Jean W. Anderson lists some of these difficulties. She quotes Mary Richmond who defined social casework as "...those processes which develop personality through adjustments consciously effected, individual by individual, between men and their social environment."[13]

Certainly, home teachers as well as social workers, each with techniques peculiar to their calling, seek to help the client help himself. According to Anderson's overview of literature on the subject,

> Counseling, too, is a part of both disciplines. Dr. MacFarland wisely commented that counseling was not one kind of workers' prerogative but was shared by all who work with the client for his rehabilitation. But social work counseling and home teacher counseling are not alike in method. Casework counseling, whether directive or non-directive, is intended to help a person in a rational way sort out issues in a situation in order to clarify his problem and conflicts, to discuss feasibility of various courses of action and free him to make a choice. ...
>
> While both caseworker and teacher are leading a client towards the enlarged adjustment, teaching is more definitive... Teachers have information to share, specific knowledge to impart, and known skill techniques to develop. These structures of facts and proven preferable methods of accomplishment are advanced by the instructor for the learner to acquire. The learner's subsequent performance can be objectively rated. ...
>
> Her [home teacher's] successful fulfillment of her assignment is based on practical but scientific techniques of

> adult education by which to impart this knowledge and these skills meaningfully and systematically, using a language understandable to her client, in the place where he is and with the facilities there available.[14]

The trend seems to be toward specialization and an increased recognition of home teachers as special educators. Francis Crawford of Western Michigan University where blind home teachers are now being trained and granted degrees in Special Education, defines the home teacher as "an enabler" -- an educator.[15] Similarly, Dickinson comments: "As social work, vocational rehabilitation, occupational therapy and other disciplines began to serve visually handicapped people, home teaching slowly gave up parts of itself to these other professions. This is in line with all historical and social progress -- just as the barber released surgery and the pastor social work."[16]

In spite of growing literature on the subject, relatively little is known on home teachers. Elizabeth Cosgrove, in the most comprehensive report so far published, states: "There was, and is, no central source of information on home teachers. The Board of Certification of the American Association of Workers for the Blind, Inc., does not have the names of all persons engaged in home teaching because many are so engaged without having been certified. The membership lists of the American Association of Workers for the Blind, Inc., and of the regional conferences of home teachers -- Eastern, Midwestern, and Western -- are incomplete since all practitioners are not necessarily 'joiners.'"[17]

The same writer reports: "Of 110 agencies visited or written to during the study, 67 agencies reported having budgeted for 326 home teacher positions under 30 titles during the current fiscal year." However, the report then presents information on only 50 home teachers interviewed by the Study staff. Although there is no indication whether or not these home teachers of the blind are representative of all such teachers in America, it may be worthwhile to quote Cosgrove's major findings: 46 home teachers were employed in public agencies, 4 in private ones; 38 were women, 12 were men; 34 were under 50 years of age, with the largest number, 15, in their 30's; 21 were married, 22 unmarried, and 7 separated or widowed; 32 had no useful sight, 15 were partially sighted but legally blind, and 3 were sighted; 17 had been in present position from 5 to 10 years, 16 between 10 and 20 years, 10 under 5 years, 5 between 20 and 30 years, and 2 over 30 years; 34 had Bachelor's or Master's degree, 6 had less than 4 years of college, 2 were Registered Nurses, and 4 had less than four years of high school; 21 had been certified, and 29 had not been certified by AAWB Board of Certification.[18]

The home teachers surveyed by Cosgrove engaged in a large variety of activities although the sequence, proportions, intensity and effectiveness of their services could not be presented. In addition to counseling, friendly visiting, record keeping and trying to "motivate clients" and interpret the special needs of the blind to individuals and groups in the community, home teachers taught mobility, activities of daily living, braille, typing, manual writing, crafts, personal grooming, table manners, etc.

"In the absence of essential determinations as to the needs and capacities either at intake or later, many home teachers were forced to perform services for which they were not prepared. Many had begun to believe they were performing those services satisfactorily. ... Although some home teachers were resourceful about using other agencies' services, others showed a marked tendency to fail to use community resources. Ingenious about getting more clients to 'get up and live,' it appeared they could get more to do so if the administrative settings were more enabling. ..."[19]

Following the publication of the Cosgrove report in 1961, there has been a marked increase of interest in home teaching. And, what is undoubtedly of crucial importance, "since 1963, the applicants aspiring to become home teachers have been able to enroll in a curriculum at Western Michigan University designed to prepare them for their profession."[20]

Although home teaching is one of the first and oldest constructive approaches geared at the rehabilitation of the blind, it has only recently achieved the major advantages of a fully recognized and specialized profession. The new home teacher of the 1960's is a professional and a specialist with a Master's Degree in Special Education. Yet, as Father Carroll pointed out, the home teacher must also continue to be "an example to be emulated, ... an emissary of the state, an agent of the body politic." He must go on "to bring friendship, company, communication and a sense of accomplishment to those for whom life might otherwise be at an end." Above all, it is a home teacher's "privilege to bring love to those from whom love has gone."[21]

3. The Cleveland Project: Home Teaching of the Newly Blinded Geriatric Clients

Although the Cleveland Society for the Blind (henceforth referred to as Society) has for many years counted blind home teachers among its employees, its desire to extend services and research in this area led it to submit an application for partial funding to the U.S. Administration on Aging. Its proposal for a joint, Cleveland-based "Home Teaching of the Newly Blinded Geriatric Clients Project" was approved. In April, 1966, a comprehensive three year demonstration project was started.

During the first months of the project (April through July, 1966) the needed preliminary work was completed under the direction of Harold W. Drane, a trained and experienced social worker and administrator, as Project Director.[22] This work included the planning of the home teaching contents, the outline of a flexible curriculum as well as the development of a research design and of such basic research instruments as the Rating Sheets,[23] models for case records, etc. The basic services which were outlined and put on the Rating Sheets included personal grooming, homemaking, cooking, communication, and leisure time activities.

In August, 1966, Mrs. Eleanor L. Underwood was appointed Principal Investigator of the newly established project. With nine years of experience as home management and crafts instructor for the Cleveland Society for the Blind and background as a home economics public school teacher, occupational therapy aide and volunteer worker, she was to be responsible for the initial contact of clients, the ratings of their skills and attitudes on a before-and-after basis, and the general functioning of the project, including supervision of home teachers, record keeping, etc.

Miss June Jenkins and Miss Suzanne Johnson, both blind since childhood and recipients of Master Degrees in Special Education, Program for Training Home Teachers of the Adult Blind, awarded by the Western Michigan University, were hired as project's home teachers.

In May, 1967, Dr. Giles Edward Gobetz, a sociologist and former certified psychiatric social worker, assumed responsibilities for research. Clerical help was provided for the entire duration of the project.

Quarterly Progress Reports to the U.S. Administration on Aging, copies of which were mailed to several other agencies, generated considerable interest for the project among home teachers, administrators, home teaching students and a small number of scientists.

There were frequent consultations with other members of the Society, including the Society's Executive Director, Cleo B. Dolan, who maintained an active interest in the project from beginning to end.

General rehabilitation conferences, as well as special meetings of the home teaching staff, supplemented the informal contacts among the project staff members.

Officially, the project lasted three years, from April 1, 1966, to the end of March, 1969. The actual work, of course, did not completely coincide with this official period. It started with discussions of the field and the planning of the proposal several months earlier. And it continued through July, 1969, when the final pages of this publication were written.

Unfortunately, as it is frequently the case with temporary demonstration projects, both home teachers left a few months before the official termination of the project. Miss Johnson left in October, 1968, to become a home teacher in Kalamazoo, Michigan, and Miss Jenkins accepted an assignment at the Veterans Hospital in Palo Alto, California, at the end of December, 1968.

Two persons were hired on a part-time basis to assist the Principal Investigator in terminating or transferring the home teaching services as smoothly and gracefully as possible.

The Cleveland demonstration project in home teaching of the newly blinded geriatric clients is probably the most ambitious demonstration program yet developed in the area of home teaching among the aged blind in cooperation with the U.S. Administration on Aging and employing professionally trained blind home teachers who were among the first graduates of the Western Michigan University's Program for Training Home Teachers of the Adult Blind.

The Cleveland Society for the Blind, being among the largest and most modern establishments of its kind in the world and the first agency in the United States to have received accreditation by the National Accreditation Council for Agencies Serving the Blind and Visually Handicapped,[24] considered itself very fortunate to add this comprehensive home teaching project to the list of its demonstration programs.

It viewed it as a special challenge to test its resources in an area on which there were almost no established precedents or guidelines to follow. The challenge was faced and some of the results are presented in this publication. Many clients were helped and it is hoped that much was learned in the process.

The authors are, of course, painfully aware of a number of limitations (avoidable and unavoidable) of this project, including those in their own work which had to be squeezed in among other assignments on an extremely crowded schedule. They hope, nevertheless, that the findings reported in this publication may be useful to other practitioners, educators and researchers (especially home teachers, social workers, sociologists and psychologists) who are concerned with the well-being of the growing numbers of our blind and aged fellow-citizens in particular and with understanding the fascinating aspects of man's learning and adjustment in general.

FOOTNOTES

1. Elizabeth Cosgrove, Home Teachers of the Adult Blind, Washington, D.C.: American Association of Workers for the Blind, 1961, p. 12.

2. Ibid., p. 12. See also, Services for Blind Persons in the United States, New York: American Foundation for the Blind, November, 1960, p. 35 ff.

3. Thomas J. Carroll, Blindness: What It Is, What It Does, and How to Live With It, Boston: Little, Brown and Company, 1961, p. 11.

4. Ibid., pp. 14-79 ff.

5. Hector Chevigny and Sydell Bravermann, The Adjustment of the Blind, New Haven, Conn.: Yale University Press, 1950, p. 191. See also Dr. Thomas R. Yanes, Ciegos, Habana: Editorial Echevarria, 1956, pp. 40-50 ff.

6. Cf. Dr. Louis S. Cholden, "Some Psychiatric Problems in Rehabilitation of the Blind," Bulletin of the Menninger Clinic, Vol. 18, No. 3, May, 1954, and A Psychiatrist Works with Blindness: Selected Papers, New York: American Foundation for the Blind, 1962.

7. Raymond M. Dickinson, "The Discipline of Home Teaching," The New Outlook for the Blind, December, 1956, p. 393.

8. Herbert Rusalem, Ed. D., "The Status of Home Teaching as a Profession," The New Outlook for the Blind, September, 1960, p. 240 ff.

9. Saul Freedman, "Home Teaching Potentials in the Rehabilitation Process," The New Outlook for the Blind, November, 1966, p. 285.

10. Raymond M. Dickinson, "Why Do We Need Home Teachers?" The New Outlook for the Blind, September, 1963, p. 264 ff.

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11. T. F. Gilmartin, "Home Teaching and Social Casework," *Outlook for the Blind*, February, 1946.

12. S. L. Forward, "Home Teaching a Specialty," American Association of Workers for the Blind, *Proceedings*, 1951.

13. Jean W. Anderson, "Home Teachers *Are* Teachers," *The New Outlook for the Blind*, May, 1965, p. 171 ff.

14. *Ibid.*, pp. 171-172.

15. *Ibid.*, p. 172.

16. Raymond M. Dickinson, "Why Do We Need Home Teachers?" *The New Outlook for the Blind*, September, 1963, p. 264.

17. Cosgrove, *op. cit.*, p. 26.

18. *Ibid.*, pp. 26-30.

19. *Ibid.*, pp. 34-48.

20. Freedman, *loc. cit.*, pp. 286-287.

21. Rev. Thomas J. Carroll, "Home Teaching -- Whence and Whither," *The New Outlook for the Blind*, December, 1956, pp. 388-392.

22. For brief biographical sketches of project personnel see Appendix III.

23. See Appendix I.

24. For information on the Cleveland Society for the Blind, see Eva Brewer Palmer, Allan W. Sherman, Cleo B. Dolan *et al.*, *The Cleveland Society for the Blind, 1906-1960*, Cleveland: The Cleveland Society for the Blind, 1961; The Cleveland Welfare Federation, *The Cleveland Society for the Blind: Periodic Review of Agency Program and Operation*, Cleveland, Ohio 1962; Arthur C. Kaufman and Associates (Management Consultants), "Visits to Other Agencies Serving the Blind: Cleveland Society for the Blind," *Report on a Management and Operating Study of Pennsylvania Working Home and Philadelphia Association for the Blind*, Philadelphia, Pa.: A. C. Kaufman and Associates, 1967, pp. 65-72 ff. For most recent information, consult *1968 Annual Report*, The Cleveland Society for the Blind.

II. PROJECT POPULATION

4. The Newly Blinded Geriatric Clients - Blind Less than Ten Years

The core of the project population consisted of 132 clients who were "newly blinded," i. e., blind no longer than ten years, and at least sixty years old. This was the major experimental group which received the home teaching services under the designation of the newly blinded geriatric clients. We shall first consider various characteristics of this major experimental group.

In Table 1, the frequency and percentage distributions of the newly blind geriatric clients are presented by age and sex. A glance at the table shows a heavy concentration of clients in age categories between 65 and 84 years (slightly over 80 per cent of all clients). Further examination of data on age reveals an age range of 37 years (between 60 and 97 years). Median age for this group was 77 years, i. e., half of all newly blinded experimental clients were younger than 77 years and the remaining half were older. The arithmetic mean age was 76.63 years.

Table 1. Frequency and Percentage Distribution of Newly Blind Clients by Age and Sex

Age	Male		Female		Total	
	f	%	f	%	f	%
60 - 64	3	6.12	7	8.43	10	7.58
65 - 69	8	16.33	18	21.69	26	19.70
70 - 74	11	22.49	7	8.43	18	13.64
75 - 79	14	28.57	17	20.48	31	23.48
80 - 84	10	20.41	21	25.30	31	23.48
85 - 89	3	6.12	8	9.64	11	8.33
90 - 95	--	--	3	3.61	3	2.27
96 - 100	--	--	2	2.41	2	1.52
Total	49	100.04	83	99.99	132	100.00

Almost 63 per cent of all clients were females, while males accounted for a little more than 37 per cent of the entire newly blinded population. Females were somewhat older than males, with over 59 per cent of all women being 75 years old or older, while only 55 per cent of all males were in that category. Generally, then, it could be said that the experimental population consisted of clients most of whom were of fairly advanced age.

Table 2 shows that 104 clients, or almost 79 per cent of the newly blinded experimental population, were white. The remaining 28 clients, or somewhat over 21 per cent, were Negro.

Table. 2. Frequency and Percentage Distribution of Newly Blind Clients by Race

Race	Frequency	Percentage
White	104	78.79
Negro	28	21.21
Total	132	100.00

Table 3. Frequency and Percentage Distribution of Newly Blind Clients by Religion

Religion	Frequency	Percentage
Protestant	82	62.12
Catholic	40	30.30
Jewish	1	.76
Other	9	6.82
Total	132	100.00

Table 4. Frequency and Percentage Distribution of Newly Blind Clients by Marital Status

Marital Status	Frequency	Percentage
Widowed	88	66.67
Married	33	25.00
Single	8	6.06
Divorced	3	2.27
Total	132	100.00

As indicated by Table 3, slightly over 62 per cent of all newly blind experimental clients were Protestant, somewhat over 30 per cent were Catholic, fewer than one per cent were Jewish, and almost seven per cent belonged to other denominations or no denomination at all.

A glance at Table 4 shows that approximately two-thirds of all clients were widowed, one-fourth were married, 6 per cent were single, and somewhat over two per cent were divorced.

Table 5. Frequency and Percentage Distribution of Newly Blind Clients by Living Arrangements According to Sex

Living Arrangement	Male		Female		Total	
	f	%	f	%	f	%
Living in Apartment	4	8.16	3	3.61	7	5.30
Living in Institution	5	10.20	8	9.64	13	9.85
Living with Relatives	1	2.04	2	2.41	3	2.27
Living with Spouse	22	44.90	7	8.43	29	21.97
Living with Child	8	16.33	23	27.71	31	23.48
Living Alone - Some Help	4	8.16	10	12.05	14	10.61
Living Alone - No Help	5	10.20	30	36.14	35	26.52
Total	49	99.99	83	99.99	132	100.00

From Table 5 we see that just over one-fourth of all clients lived alone and had no outside help. Next largest number of clients lived with their children and nearly the same proportion lived with their spouses. Somewhat over ten per cent of clients lived alone, but had some arrangements for outside help, and almost ten per cent lived in institutions. Very few clients lived in large apartment houses (just over 5 per cent) and the smallest proportion lived with relatives other than children (a little over two per cent). Thus we see that considerable variety characterized the living arrangements of the experimental newly blind geriatric population.

A glance at Table 6 shows that considerably more Negroes than whites lived with their children, another major difference being that no Negro client lived in an institution. Also, more Negroes than whites lived alone, with no outside help, and more whites than Negroes lived with their spouses.

Table 6. Frequency and Percentage Distribution of Newly Blind Clients by Living Arrangements According to Race

Living Arrangement	White		Negro		Total	
	f	%	f	%	f	%
Living in Apartment	5	4.81	2	7.14	7	5.30
Living in Institution	13	12.50	0	--	13	9.85
Living with Relatives	2	1.92	1	3.57	3	2.27
Living with Spouse	25	24.04	4	14.29	29	21.97
Living with Child	22	21.15	9	32.14	31	23.48
Living Alone - Some Help	12	11.54	2	7.14	14	10.61
Living Alone - No Help	25	24.04	10	35.71	35	26.52
Total	104	100.00	28	99.99	132	100.00

As shown in Table 7, most clients, or somewhat over one-third of the project population, were blind less than one year; one-fourth were blind two years, and somewhat less than 17 per cent were blind between two and three years. Thus, over 75 per cent of these experimental clients were blind less than three years, and somewhat less than one-fourth were blind between three and ten years. The designation "newly blind," while always arbitrary, must be considered in this context.

Table 7. Frequency and Percentage Distribution of Newly Blind Clients by Duration of Blindness

Duration of Blindness	Frequency	Percentage
10 years	3	2.27
6 years	2	1.52
5 years	5	3.79
4 years	11	8.33
3 years	22	16.67
2 years	33	25.00
1 year	45	34.09
Gradual	7	5.30
No Data	4	3.03
Total	132	100.00

Table 8. Frequency and Percentage Distribution of Newly Blind Clients by Causes of Blindness

Causes of Blindness	Frequency	Percentage
Macular Degeneration	34	25.76
Diabetic Retinopathy	30	22.73
Glaucoma	22	16.67
Cataracts	17	12.88
Optic Atrophy	8	6.06
Macular Hemorrhages	5	3.79
Chorioretinitis	3	2.27
Macular Scarring	3	2.27
Retinal Detachment	2	1.52
Arteriosclerosis	2	1.52
Corneal Dystrophy	2	1.52
Aphakia	1	.76
Burn Injury	1	.76
No Data	2	1.52
Total	132	100.03

Table 9. Frequency and Percentage Distribution of Newly Blind Clients by Disabilities Other Than Blindness

Disability	Frequency	Percentage of Clients	Percentage of All Disabilities
Diabetes	38	28.79	24.84
Heart Condition	23	17.42	15.03
Arthritis	16	12.12	10.46
Hearing Loss	15	11.36	9.80
Stroke	13	9.85	8.50
Arteriosclerosis	5	3.79	3.27
High Blood Pressure	5	3.79	3.27
Hypertension	4	3.03	2.61
Difficulty in Walking	3	2.27	1.96
Emotionally Disturbed	3	2.27	1.96
Fractured Hip	3	2.27	1.96
Partial Paralysis	2	1.52	1.31
Chronic Kidney Infection	2	1.52	1.31
Obesity	2	1.52	1.31
Back Injury	2	1.52	1.31
Surgery for Cancer	2	1.52	1.31
Angina Pectoris	1	.76	.65
Chronic Bladder Infection	1	.76	.65
Ulcer	1	.76	.65
Paraplegic	1	.76	.65
Double Amputee	1	.76	.65
One Leg Amputated	1	.76	.65
Hernia	1	.76	.65
Asthma	1	.76	.65
Dizziness	1	.76	.65
Sinus	1	.76	.65
Emphysema	1	.76	.65
Leg Injury	1	.76	.65
Speech Defect	1	.76	.65
Poor Circulation	1	.76	.65
Alcoholism	1	.76	.65
Total	153	115.96*	99.96

*Since the number of disabilities per client differs, the total percentages do not add up to 100.00.

Table 8 presents frequency and percentage distribution of the newly blind geriatric clients by causes of blindness. Macular degeneration and diabetic retinopathy account for nearly half of all blindness, followed by glaucoma and cataracts, in that order. All other causes together are responsible for only somewhat more than one-fifth of all loss of sight.

Disabilities other than blindness are listed in Table 9. One-fourth of all clients suffered from diabetes, with heart condition, arthritis, hearing loss and stroke following in that order. Thirty-one disabilities are listed, yet it is the first five disabilities which account for nearly 59 per cent of all disabilities, while the remaining 26 disabilities account for only 41 per cent of the total.

As shown in Table 10, only slightly over one-fifth of all experimental newly blind geriatric clients had no known disability other than blindness and, perhaps, old age, which was not counted. The largest single proportion of clients, or over 46 per cent, suffered from one known disability; one-fourth suffered from two, and less than 8 per cent from three or more.

Table 10. Frequency and Percentage Distributions of Newly Blind Clients by Number of Disabilities Per Client

Disability	Frequency	Percentage
None Reported	28	21.21
One	61	46.21
Two	33	25.00
Three	10	7.58
Total	132	100.00

The above presentation exhausts the major population characteristics of the experimental newly blind geriatric clients. For experimental and research purposes, two other small groups of clients received services in our home teaching demonstration project. In addition, as shown in Table 11, 7 clients died, 11 rejected services, and on 14 clients the data were so incomplete that they were not included in our research although they were among those receiving services.

Table 11. Frequency and Percentage Distribution of Other Categories of Clients by Sex

Category	Male		Female		Total	
	f	%	f	%	f	%
Blind Over 10 Years	4	22.22	7	21.88	11	22
Apartment Group	4	22.22	3	9.38	7	14
Incomplete Data	5	27.78	9	28.13	14	28
Deceased	1	5.56	6	18.75	7	14
Rejected Service	4	22.22	7	21.88	11	22
Total	18	100.00	32	100.02	50	100

5. Clients Blind Longer than Ten Years

The first of these additional groups consisted of eleven clients (7 females and 4 males), age 44 to 81 years (with an average age of 69 years) who were blind between 17 and 53 years, or an average duration of blindness of over 40 years. This group, while unfortunately not perfectly matched on all studied variables with the experimental group of the newly blind clients, was also exposed to the same project experiences as the major experimental group of the 132 newly blind clients.

Table 12. Frequency and Percentage Distribution of Clients Blind Over Ten Years by Duration of Blindness

Duration of Blindness	Frequency	Percentage
53 years	1	9.09
50 years	1	9.09
48 years	2	18.18
37 years	1	9.09
36 years	2	18.18
35 years	1	9.09
30 years	1	9.09
21 years	1	9.09
17 years	1	9.09
Total	11	99.99

6. Apartment Group Clients

Another small group of only seven clients (4 males and 3 females) was not taught at home as all other experimental clients, but in the Society's "experimental apartment" located in the Sight Center building. This small group was used in a preliminary experimental search for possible alternatives to the traditional home teaching approach. It was referred to simply as the "apartment group."

7. Other Categories

Seven experimental newly blind clients died during the demonstration project and a total of eleven clients rejected the offered home teaching services. Inevitably, 14 clients could not be included in our research because of incomplete data.

To the core group of 132 experimental newly blind geriatric clients one should, therefore, also add 11 clients blind 17 years or longer, 7 "apartment" clients, 7 clients who died and 14 clients whose records were incomplete. This adds up to 171 clients with whom the project staff had worked, not counting the eleven clients whom they could not convince to accept services.

The Principal Investigator also took ratings on 44 members of the control group who were also included in our research. Adding 44 controls to the 171 experimental clients, we get the grand total of the Cleveland home teaching demonstration project, namely 215 geriatric blind.

8. Clients Who Rejected Services

The eleven clients who rejected home teaching services represent only six per cent out of the total 182 clients who were invited to participate in the home teaching action groups (171 clients cooperated). Because of the lack of cooperation, there was no opportunity to discover their "special" characteristics which made them unwilling to accept services. Their age range was from 60 to 85; 4 were males and 7 females; 4 were widowed, 5 married and for 2 the marital status was unknown; 4 were white, 5 Negro, and the race of the remaining two was not recorded; one had no known disability other than blindness; 5 had one disability each, 4 suffered from two disabilities, and one suffered from three disabilities other than blindness; 8 were Protestant, one was Catholic, and for the remaining two no data on religion were available.

These characteristics, of course, in no way suggest why these particular blind persons rejected services. A hypothetical suggestion is that they represented extremes in personality independence or dependence, the former wanting to achieve everything on their own and rejecting the home teaching services for that reason, while the latter were completely dependent on others and refused lessons for fear that they should then become more independent and do more for themselves. Denial of blindness and hence of services for the blind is another possibility. Unfortunately, we had no way of testing this hypothetical interpretation.

* * *

To sum up, 171 clients, or 94 per cent of those invited, cooperated in our experimental groups, and 44 clients in the control group, or 215 clients in the entire home teaching demonstration project.

III. THE HOME TEACHING PROCESS

9. Setting the Stage for Home Teaching

The victims of old age, blindness and various accompanying disabilities are frequently much more isolated than other members of our modern, industrialized society, not only from society in general, but also from the available social services.

As mentioned earlier, there is an informational lag. Mobility is difficult or it may even appear to be impossible. Sometimes, it is impossible. Some persons are reluctant to seek or accept services, while others feel that their disabilities justify their complete dependence on their spouses, children, relatives, friends or various institutions. Many old people are convinced that they can no longer learn new tricks. Many are in doubt. Others who may wish to learn, frequently don't know about the community resources which may be available to them.[1]

While blind children and younger adults are relatively easily reached, the shell of isolation is much more difficult to break in the case of the geriatric blind.

The Cleveland Society for the Blind has persistently used numerous channels in trying to reach the unreached: frequent notices and announcements on the radio and TV; leaflets, brochures and newspaper publicity; close cooperation with numerous other public agencies and institutions and with ophthalmologists and other medical specialists; information provided by its established clients, their relatives and friends; and aggressive social work and community services.

In these ways, scores of geriatric blind clients were reached each year. Since the beginning of the home teaching demonstration project, the legally blind persons aged sixty or over have automatically become candidates for the home teaching services. They were at first processed as any other clients, receiving the usual medical examinations which established the degree and kind of their visual handicap and other disabilities. Those who were still in the stage of the initial shock or in the period of mourning for the loss of their sight (discussed in Chapter I) were assigned to a caseworker who tried to facilitate their adjustment by means of casework, group work, volunteer visiting, camping at Society's Highbrook Lodge or other promising strategies.

All other blind persons over sixty and residing in Cleveland or vicinity were put on the list of the home teaching demonstration project.

Those assigned to the experimental group were in due time contacted by the Principal Investigator who made an appointment and then visited them in their respective places of residence. The Principal Investigator explained to the prospective client the availability and contents of home teaching services and also rated the client's skills and attitudes on the CSB Rating Sheet. If the client accepted the offered home teaching services, he was informed by the Principal Investigator that a totally blind home teacher would soon make an appointment and then come to see him at mutually convenient intervals.

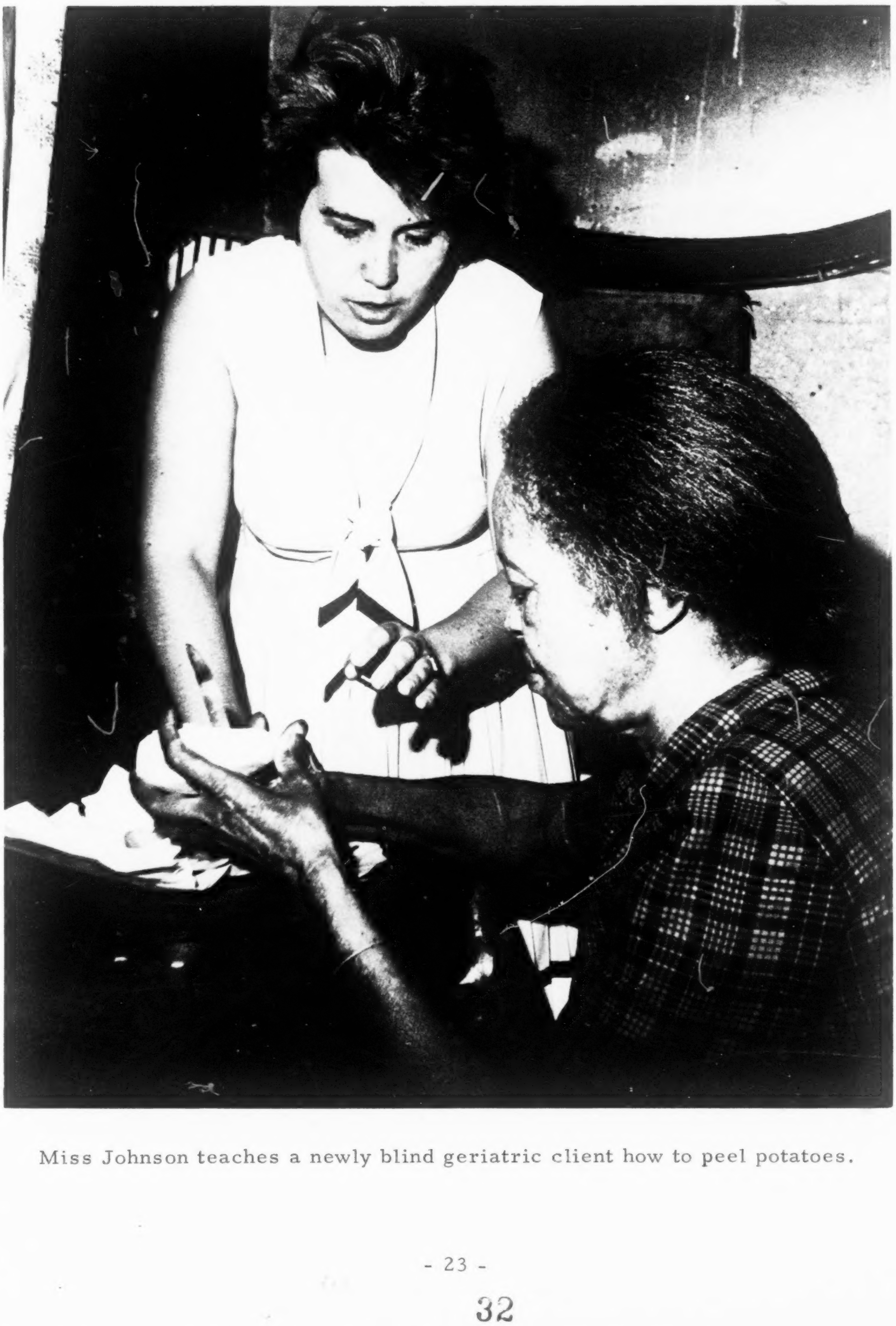
Members of the control group were visited and rated in the same way, but no definite services were offered at that time, although the possibility of "new programs" at some future date was mentioned. (Because of great geographic dispersion, mutual contamination of cases, in terms of research, seems to be extremely unlikely.)

Members of the experimental group were then randomly assigned to one of the two home teachers. The teacher subsequently made an appointment, visited the client in his or her place of residence, devoted some time to establishing rapport, inquired about the needs of the client and started to teach those skills in which the client was interested and for which he was physically and emotionally ready.

Teachers kept their own records, composed of short recordings of contacts and lessons, impressions and, at times, letter grades.

10. Skills Which Were Taught by the Home Teachers

As it is usually the case in home teaching, a large variety of skills were being taught, although the lessons were highly individualized to fit the needs, abilities and interests of each client.



Miss Johnson teaches a newly blind geriatric client how to peel potatoes.

As outlined on the Rating Sheet, personal grooming, homemaking, cooking, communication and leisure time activities represented the core of the home teaching curriculum.

Under each heading, several skills were taught. Personal grooming included combing or setting hair, applying lipstick, tying necktie and shoes, polishing shoes, personal hygiene, etc.

Homemaking consisted of lessons in ironing, cleaning tables, dusting furniture, sweeping, threading a needle, sewing by hand or machine, ironing, etc.

Several tasks were taught in the area of cooking: lighting the burner, setting and judging heat, filling a cup or other container with solid foods or with liquids, spreading butter on bread, peeling and slicing, etc.

Among the communication skills, clients were taught how to dial a telephone number, identify coins, tell time, sign name with a signature guide or write with the aid of a script-board, operate radio, television or a talking book machine, etc.

Similarly, help was given with leisure time activities -- crafts, hobbies, visits, playing games, etc.

Unfortunately, the Rating Sheets included only the anticipated core activities. Home teachers taught many other skills, including braille, typing, elementary mobility, etc. Systematic ratings of these latter skills would, of course, be of great value for purposes of this research.

Let us now accompany our home teacher on her visits to a client. Let Mr. E., an actual case, be the client. The home teacher is in her office at the Sight Center. Here she has first confirmed the appointment. She checked the records in braille, then, some 40 minutes before the appointment time, she carefully filed the records. Now she took her white cane, closed the office door, walked through the Sight Center almost as if she were a sighted young person, then headed for the bus stop around the corner.

"What a courageous young lady!" you say to yourself. As she descends the bus in the ghetto and, with her white cane in front of her, heads for Mr. E.'s apartment, you are even more amazed at her courage and skill.

"... He was taught to use the signature guide and his wife enthusiastically praised his signature as being quite legible. From now on Mr. E. will be able to sign his Social Security check -- a matter which, like independent dialing, seems to contribute to his self-confidence and morale." Above, Miss Jenkins teaches Mr. E. script writing.

Now the crucial question arises: "What can a young blind home teacher teach an elderly newly blinded man?" The answer to this question can best be summed up from the records. Let us read them together:

> Mr. E. received instruction in several important home teaching areas. As personal grooming has become quite problematic after his loss of sight, he was taught various grooming skills, including how to shave. The client was used to a safety razor and was somewhat fearful at first, but he did eventually try shaving and was able to do it successfully. An electric shaver would, of course, minimize the danger of cuts and scrapes and, as the client was unable to buy one, the Cleveland Society for the Blind repaired an old electric shaver which was then put at the client's disposal.
>
> Mr. E. was also given instruction in telephone dialing, a skill which enabled him to be more independent in his communication with others. He was taught to use the signature guide and his wife enthusiastically praised his signature as being quite legible. From now on, Mr. E. will again be able to sign his social security check -- a matter which, like independent dialing, seems to contribute to his self-confidence and good morale. The client was also given instruction in the tactual identification of coins and learned how to fold and put away paper currency of various denominations, so that he now knows the value of various bills.
>
> Mr. E. was also taught how to pour cold liquids and this simple task caused almost no anxiety. Empty milk cartons were used for this purpose and the client filled them up several times with comparatively little difficulty.
>
> In the next lesson, the pouring of hot liquids was taught. For this purpose, a coffee pot which had been filled with hot tap water was used. The tap water gives some indication of warm temperature, but it is not hot enough to cause fear of burning. Mr. E. stated that he had practiced with the cold water during the week and this effort caused him to have much less difficulty pouring from the coffee pot into a cup.

> In the next lesson, the client was given instruction in the making of coffee. The coffee pot was used again. Mr. E. measured the coffee by teaspoonful into the coffee pot. He was taught to locate the pot with the free hand and to use the paper on the jar for leveling. He then measured the cold water into the pot by cupful as the coffee pot is not marked. The pot was then placed on the stove and the burner lighted. Mr. E. immediately understood that it was necessary to place the pot prior to lighting the burner and to extinguish the burner before removing the pot. When the coffee came to a boil, Mr. E. removed it from the range and poured it into cups. Having completed this task under the guidance of the home teacher, he wanted to repeat the steps again and was able to do so unaided. Mr. E. soon gained sufficient confidence in his own ability to be able to prepare a simple meal for himself.
>
> Mr. E., who has learned several useful skills, was always quite pleased when he acquired a new skill. In the initial lessons, he seemed to need support and encouragement of his wife, but after a few lessons he was beginning to show some self-confidence and pride in being able to do certain things by himself.

Mr. E. lives in Hough where even sturdy truck drivers feel uneasy and apprehensive. But nothing has ever happened to either of the Society's home teachers, although they were young and blind and would be relatively helpless in an emergency. Our blind home teachers, of course, visited clients all over Cleveland, as well as in Euclid, Shaker Heights and Parma. About half of the trips were made by bus, after a careful study of relief maps. Other less accessible places were reached with the help of taxis and volunteer drivers. Several home teaching visits were made each week, with the rest of time being spent on record keeping, conferences, provisions of home teaching supplies (self-threading needles, script-writing boards, signature guides, dial-aids, etc.).

11. Illustrations from Case Studies

Brief illustrative case studies may give us additional valuable insights into what transpired during the home teaching visits, what was taught and learned and in what manner, and how the teachers and clients interacted during the home teaching process. Case studies are, of course, also a very good source of hypotheses for research and clues in the interpretation of findings.[2]

An attempt is being made to present a sample of both the relatively successful and unsuccessful clients as well as of those in-between. Unfortunately, the earlier background information is not always available.

The case of Mrs. K., a 61 year old client suffering from diabetic retinopathy and tactual impairment whose "nervousness" and physical disabilities kept her from fully profiting from the home teaching services.

The client lives with her thirty year old daughter who is a widow with two children, age seven and ten. The client's husband works in a managerial capacity out of town and returns to his family only on weekends. The client's daughter is employed in clerical work and performs most of the housekeeping chores after work.

Mrs. K. first contacted the Cleveland Society for the Blind in connection with the talking book machine services in January, 1967. Her caseworker, Mrs. Tatiana Graper, established a good rapport, provided the authorization for the talking book machine and then referred the client to the Principal Investigator for the home teaching services.

On February 9, 1967, Mrs. Underwood called at Mrs. K.'s home, in a residential suburb of Cleveland. Mrs. Underwood summed up her initial impressions in the following statement:

> Mrs. K. is very friendly and interested in services of the Cleveland Society for the Blind. Although she has no residual vision, she has little difficulty in orientation about the house. She lacks confidence in her ability to do any of the normal activities of daily living, such as housekeeping, cooking, etc., but would like help in learning techniques for the non-sighted. She demonstrated, nevertheless, her ability to use the stove and the other functions and procedures listed in the rating scale. One of her daughters, her husband and infant son came to visit Mrs. K. while the Principal Investigator was there. The daughter was much interested in the rating tests given Mrs. K. and agreed that her mother should be more independent. But the daughter with whom the client lives is apparently more protective and fearful that her mother may burn or injure herself in cooking or performing the housekeeping tasks. There seems to be a warm family relation-

Ironing is one of the many homemaking skills which the newly blind geriatric clients were being taught by their totally blind home teachers. In this picture, Mrs. P. receives a lesson in ironing from Miss Jenkins.

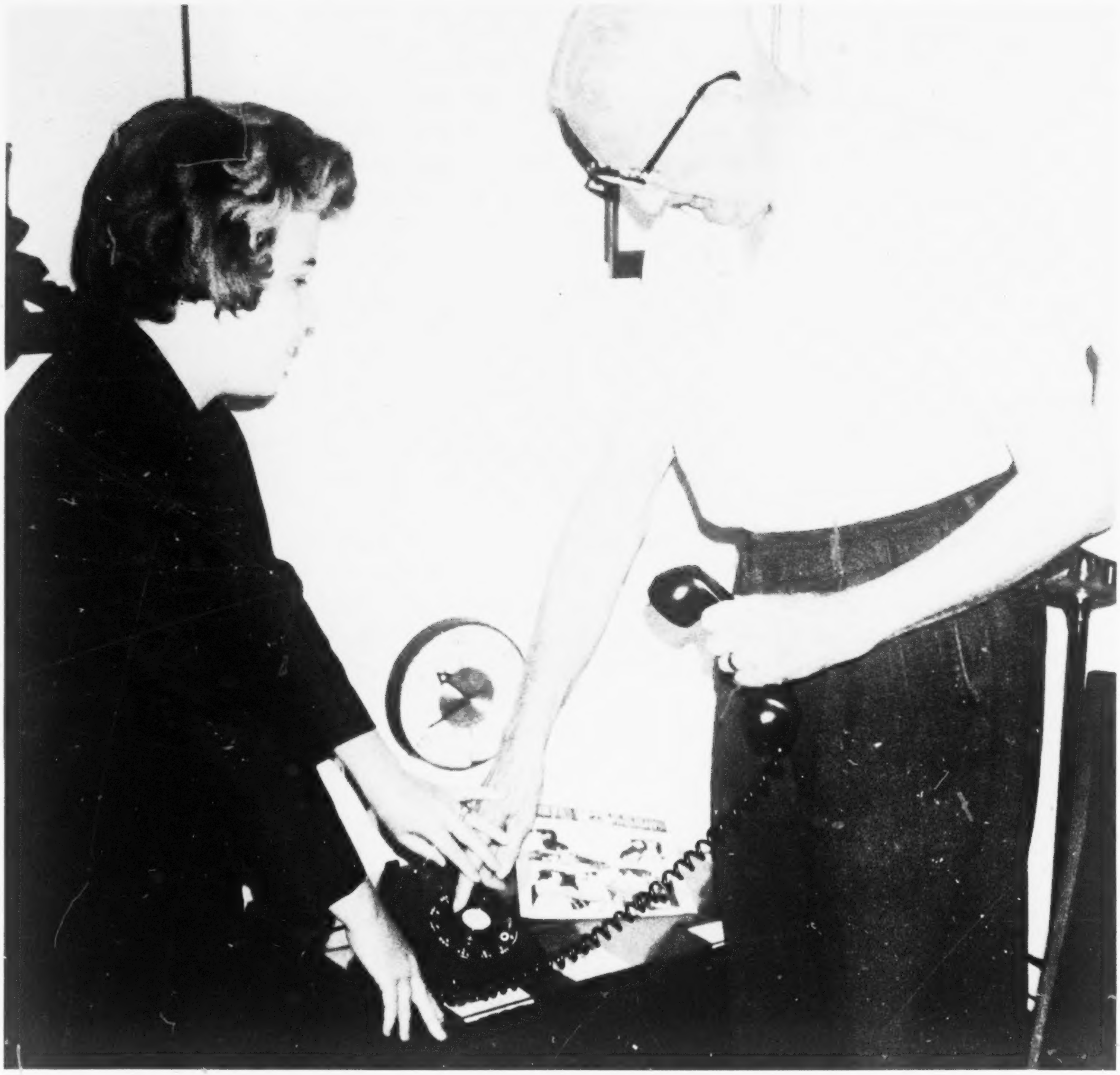
ship and Mrs. K. has many friends who visit with her and take her out to church and other social activities.

After this initial visit by the Principal Investigator, Miss Suzanne Johnson, the project's totally blind home teacher, started visiting Mrs. K., usually about once weekly. On her first visit Miss Johnson established a satisfactory rapport with the client and discussed her needs with her. Mrs. K. stated that she was unable to identify her clothes, dial the telephone, tell time, identify coins or perform most homemaking chores. She also had trouble operating her talking book machine. Client expressed her interest in all above activities, as well as in typing and braille.

During the first home teaching lesson, the teacher showed the client the sighted guide technique and received some argument about this. The client had been using a different technique while walking with her daughter and was resistant to a new approach. Teacher also began instruction on dialing the telephone. Mrs. K. was very awkward and had very poor use of her hands. She was only able to identify parts of the telephone and to locate number "1." Here, as in other tasks, the client was interested in learning, but became highly nervous and embarrassed when unable to perfect a skill immediately.

On a subsequent visit, Mrs. K. was taught how to identify coins, but her serious tactual problem hindered her progress in spite of her strong interest and motivation. The teacher next worked with the client on identifying her clothes but again had only a partial success. The client was also taught how to use a script-writing board. While she learned how to attach paper and how to draw lines which turned out not to be entirely straight, she had great difficulty writing letters, apparently because of her tactual problem. The lesson on identifying coins was repeated and the client did considerably better than previously. The teacher then again worked with the client on dialing the telephone. Mrs. K. experienced considerable difficulty on her first trial and was very discouraged. Teacher then again showed her how to follow the edge of the dial when following from the reference point to number "1." The client now made considerable progress in this limited area.

On May 5, 1967, the teacher again visited the client and found her getting ready to go to the hospital. When the client returned a few days later, she was put on a limited, strict diet. Mrs. K. now stated she was too sick, for the time being, to continue with her lessons but hoped she would feel better in a few weeks and then resume



Telephone dialing was one of the most popular activities in the Cleveland Home Teaching Demonstration Project. Above, Miss Johnson teaches a client how to dial a number.

them. As her condition actually deteriorated, she was closed in home teaching.

In reviewing this case which was presented as Miss Johnson's illustration of a relatively unsuccessful client, one finds a high motivation and a limited amount of learning on the positive side. The client's tactual impairment and other physical disabilities, her low frustration tolerance and an overprotective orientation on the part of her daughter, on the other hand, seem to be the most obvious factors which have negatively affected the home teaching process and account for the relatively negligible and very slow progress.

The case of Mrs. H., a 63 year old widow suffering from diabetic retinopathy and a heart condition, who quickly learned to thread a needle and hem a dress, minimize bruises from accidents and give herself insulin injections, operate the range and prepare a roast.

Mrs. H. was first seen by Mrs. Carrie Turner, the Society's blind caseworker, on March 17, 1968, and received a talking book machine through Mrs. Turner's arrangements. The client was then referred for home teaching and the project's Principal Investigator, Mrs. Eleanor Underwood, made her first visit on March 21, 1968.

This is how Mrs. Underwood summarized her initial impressions:

> Mrs. H. lives with a married daughter in a secluded residential area. There are many trees and spacious yards. The home is new, on a one-floor plan, and tastefully furnished and decorated. The client's daughter has three school age children and she was baking cupcakes when the Principal Investigator arrived. There was evidently an affectionate, considerate and concerned relationship between the two women, as well as between the grandmother and her grandchildren.
>
> Mrs. H. has regretfully relinquished much of her independence, because she has been self-supporting and self-sufficient for many years. She was widowed while in her thirties and was the sole support of her children. She worked at many unskilled jobs: laundry, day work and restaurant work and was most proud that she was able to provide a good education for all of her children, although, as she said, she "was not a high school girl herself." Her son is now a successful practicing

> physician and her daughters are happily married and in comfortable circumstances. Mrs. H. derives a lot of pleasure from her grandchildren, though she says they have their own interests and she feels somewhat left out of family leisure-time activities. She owned her own home but sold it at the urging of her son and daughters.
>
> Mrs. H. formerly had many hobbies -- sewing, crocheting, and gardening, but feels she can no longer do these. She also misses her church in which she has been active. Her daughter's family is of another faith and the church services are at different locations, so that it has been difficult for her to go to church regularly.
>
> Mrs. H. went through the rating procedure willingly, but exhibited a lack of confidence in her own ability.

Mrs. Underwood referred Mrs. H. to Miss June Jenkins, the project's blind home teacher, for home teaching services. Home teaching was started early in May. This is how Miss Jenkins described Mrs. H.:

> The client is alert and states that she is not content just to sit. On the first visit, Mrs. H. quickly learned to use the self-threading needles. She then used this skill to hem a dress. Mrs. H. told the home teacher that she has sustained some bruises from bumping into pieces of furniture. She was taught some pre-cane techniques which minimized this problem. These techniques would also help her to become oriented to unfamiliar surroundings, such as the cottage where she plans to spend her vacation with her son. Mrs. H. had previously stated that she is able to clean her own room and also assists her daughter with all household cleaning. She had, however, asked for help in using the range. Mrs. H. stated that she would probably be doing more cooking than previously as her daughter would be working two days a week and it would be necessary for her to help with the preparations for dinner. Upon examining the oven control, the notch with which the numbers are matched was pointed out to Mrs. H. The client was able to feel the various numbers and learned to set the oven temperature. Mrs. H. was very pleased with this knowledge, as she is now able

to prepare a roast. The client regrets the fact that she does not have much outside activity. The home in which she lives with her daughter is not accessible to public transportation. She will be referred for group service when our social clubs resume activities in the fall.

In reviewing the case history of this client, we see several ingredients of success: her personality shows a high determination to overcome obstacles and problems, a trait which has been in evidence throughout her recorded life; she has a close and supporting family relationship which, nevertheless, is not overprotective; she has no overwhelming physical, mental or emotional secondary disabilities. While she is anxious to learn, there is no neurotic pride which would lead her to expect instant success and would result in subsequent frustration when learning proceeds at a slower or more exacting rate. This absence of neurotic pride also permits her to substitute new, more efficient techniques for her old ways and to accept, without resentment, the fact that her family may legitimately have different recreational interests than herself.[3] All these factors undoubtedly contribute to her relatively successful experiences in home teaching, as well as to her constructive adjustment to old age and blindness.

The case of Mr. S., a 71 year old, divorced, former automobile mechanic and custodian, suffering from "nearly total blindness" and hypertension, whose senility and confusion prevent him from learning various home teaching skills.

Mr. S. was born in Hungary and came to America at the age of fourteen. He has been divorced for many years. His only child, a daughter, lives with his ex-wife and does not seem to be interested in him. He is a former automobile mechanic and he retired several years ago. For about ten years he had been a custodian on the premises of Mr. L. N. For the past five years, because of his increasingly failing vision, the client was unable to perform his custodian duties but, in consideration of his previous services, Mr. L. N. lets him stay rent-free.

Mr. S. occupies one room of a dilapidated house. His room is furnished with a bed, a dresser, table, two straight chairs and a wash basin. The client used to do his own cooking on an old stove in the basement, as did some of the other roomers. Since his vision problem has become worse, he hardly cooks for himself any more. He gets by on sandwiches or, occasionally, when he has a guide, eats in a restaurant.

By early spring, 1967, it has become increasingly difficult for the client to do his grocery shopping, take his shirts to the laundry and do other necessary chores. Mrs. Tatiana Graper, the Society's caseworker who worked with the client, tried to arrange for his admission to the Benjamin Rose Institute, with no results. The client lives on his $112 Social Security monthly benefits.

Mr. S. first came to the Cleveland Society for the Blind on June 3, 1966, accompanied by a friend. The initial impressions were recorded by Mrs. Graper, his assigned caseworker, who wrote: "Client seems to be a self-sufficient, calm person. He seems to minimize the difficulties he has been experiencing." . . .

On September 16, 1966, the client was again seen by Mrs. Graper after a Low Vision Clinic appointment which she had arranged. Mr. S. mentioned his difficulty in chewing solid food which further narrowed his already limited diet. Mrs. Graper promptly explained to the client a possibility of getting the necessary dental care and made an appointment with the Home Dental Care Project. At this time the client also expressed his desire to join one of the Society's West Side social clubs and his desire was communicated to Society's Group Work Department. Arrangements also were made to include the client in the home teaching project.

On May 17, 1967, Miss June Jenkins visited Mr. S. for the first time. The client explained that he was not able to dial the telephone and seemed to be interested in help in this area. He also mentioned having some difficulty in keeping his clothing brushed.

On May 22, 1967, the home teacher tried to make an appointment for the next visit but the client said he was not feeling well. Since that date, the client was seen twice. This is how the home teacher reported on these visits:

> The client is rather senile and very confused. He did not express any hostility toward the teacher or this agency, but he is quite dissatisfied with the service he received through the Home Dental Care Project. He claims that the dentures he received do not fit properly. The federal grant under which the Home Dental Care Project was operating has apparently been terminated and it is now necessary to charge a fee, based on the patient's economic ability to pay. Mr. S. told the home teacher that he had received a form asking about his financial status. He was quite resentful of these questions.

When the home teacher called again a few days later, the client was unable to remember who she was and why she was there, but he was quite willing to try to learn to dial the telephone. Instruction in telephone

Braille can bring new light, open new horizons...

Miss Jenkins teaching braille.

dialing was given but the home teacher doubted that he was able to profit from it. As the client was walking near his home, he seemed to be completely disoriented and did not know how to return to the house. According to the home teacher, the client's confusion was illustrated also in another instance. When, prior to her last home visit, she phoned Mr. S. to schedule an appointment, the client stated that he has been trying to get someone to call a taxi for him so that he could go to the Cleveland Clinic as he was not feeling well. Several days later, in a conversation with a caseworker at Benjamin Rose Institute, the home teacher was told that the client had assured the caseworker of his ability to travel to the clinic alone by bus.

On the basis of these observations, the home teacher concluded that the client was too senile to profit from her home teaching services and the case was closed.

In reviewing the case of Mr. S., one sees a number of factors which, it seems, contributed to his relative failure in the home teaching project. One suspects a personality whose history of maladjustment is much longer than the duration of the client's blindness. Such maladjustment is suggested by Mr. S.'s hypertension, his divorce and the loss of affection of both his ex-wife and his daughter and, perhaps, by his change of employment and, more recently, his reaction to the financial questionnaire. One further suspects some maladjustment due to cultural conflicts of an immigrant struggling under the pressures of an ongoing assimilation process. In addition to these personality factors, one notes the beginnings of senility, with a loss of memory. Social environment provides only occasional support from friends, rather than a continuous atmosphere of warmth and social security.[4] The absence of financial security and the fact that Mr. S.'s diet, too, has for many years been unsatisfactory, further contributed to the weight of factors which negatively affected this client's progress in the home teaching project.

The case of Mrs. G., a well-adjusted, 88 year old wealthy widow who has learned how to identify coins, thread the needle, write with a script-writing board, clean and dust her home, make telephone calls and apply lipstick.

Mrs. G. is a rare client from the upper strata of society who enjoys many economic, social and cultural advantages. She was the wife of a wealthy businessman and led an active life, including world-wide travels. She is currently legally blind due to extensive corneal scarring in her right eye and macular degeneration in her left eye. She lives in a superior home with her sister who is a retired school teacher. The sisters share housekeeping duties but have outside help with cleaning. The client's son takes care of her business and financial affairs.

Mrs. G. referred herself to the agency in connection with a low vision aid and a talking book machine, both of which were promptly provided for her. The Principal Investigator first visited her on January 13, 1967, and was impressed by her good adjustment and her high interest in the home teaching services.

The home teacher, Miss Suzanne Johnson, immediately began to teach Mrs. G. how to identify coins and to sign her name with the help of a signature guide. Script writing was successfully learned next.

While Mrs. G.'s learning was slowed down in March and April, 1967, due to her knee injury, the home teaching was normalized in May, 1967. Now, the client learned several new skills, such as dusting and cleaning the home, using the proper sighted guide technique, telephone dialing and applying lipstick. She also discussed addresses of various research materials on blindness which were of interest to her.

Shortly before her knee injury, the grateful client told the home teacher that she wanted to give her a gift, which the latter politely declined. The client, nevertheless, remained deeply grateful and often emphasized how greatly the home teaching services had benefited her.

One sees that this client possesses many important ingredients for success in the home teaching project: a resourceful personality with good motivation, mental alertness and independence, combined with an ability to share responsibilities and accept help when needed. Her social environment is supportive, but not overprotective. There are no overwhelming secondary disabilities and the client enjoys good economic security. All these factors, undoubtedly, contribute to Mrs. G.'s success in the home teaching project, in spite of her relatively advanced age.

The case of Mrs. Z., age 85, a highly motivated client who finally succumbs to her severe multiple disabilities.

The client who suffers from diabetic retinopathy was first contacted by Mrs. Underwood, the Principal Investigator, on September 22, 1966. Mrs. Z. greeted Mrs. Underwood at the front door as two young women and two small children were departing. Mrs. Z. explained that these were two granddaughters and two great-grandchildren. "...Here, obviously, there is an affectionate and close family relationship," wrote Mrs. Underwood in her notes. Mrs. Z.'s son, who was widowed eleven years ago and has a severe heart condition, lives with her. She has two married daughters, sixteen grandchildren and two great-grandchildren. Her husband died more than thirty years ago and she supported herself and family by doing housework, laundry and working in a factory, at various times. She has been a diabetic since she was about thirty years old She also had operations for fibroid tumors. Her leg was amputated three years ago and she now has an artificial leg. Mrs. Z. said that this did not greatly restrict her mobility, until she fell and broke her hip about ten months ago. Now, she gets about mostly in her wheelchair, though she does use a walker sometimes. She also has a tripod cane and she immediately demonstrated to Mrs. Underwood her ability to walk with this. She said that she occasionally walked down the street accompanied by a friend to a beauty parlor nearby to get a permanent.

Mrs. Z., in addition to the above mentioned disabilities, has a heart condition for which she regularly takes digitalis, a dislocated shoulder and asthma so severe that she frequently has to sit up in bed for most of the night.

In spite of all these disabilities, Mrs. Z. cares for herself entirely, including dressing and giving herself injections of insulin (though her son checks the amount in the syringe). She does ironing, cooking and dusting. She is unable to light the oven or do the sweeping and vacuuming, but her son does this and he also cares for the yard. She even canned tomatoes from their garden. At the time of the first visit by the Principal Investigator, she still enjoyed visits from her family and friends and neighbors and they all visited her fairly often. She had made dozens of piece quilts, which she gave to her daughters and granddaughters, but is now unable to thread a needle. She used to do a lot of crocheting and knitting and feels she would like to have some hand work to do again, as well as to have a talking book machine and records. On Mrs. Underwood's first visit, the client also expressed an interest in joining, at a later date, some group affiliated with the Cleveland Society for the Blind.

Miss Jenkins, the home teacher, visited Mrs. Z. on October 4, 1966, and immediately established a good rapport with her. In the course of conversation, the client became interested in telephone dialing, the self-threading needle and the talking book machine. Although Mrs. Z. was short of breath due to asthma and felt quite nauseated, in her opinion, due to a double dose of digitalis which her doctor had recently prescribed, the visit was a friendly and pleasant one.

By October 18, 1966, when Miss Jenkins visited the client for the second time, the latter had received a talking book machine. Instruction on its operation was given and, although the client had some difficulty in setting the speed control lever for the neutral position, she adequately learned how to operate the machine.

Unfortunately, Mrs. Z.'s medical condition deteriorated very rapidly. By December 13, 1966, when the Principal Investigator visited her again, the client "lost much of the sparkle and interest in life that she had displayed on the first visit." Although she had earlier enjoyed visits and showed interest and adequate ability in learning the operation of a talking book machine, the use of a self-threading needle and the telephone dialing, she now stated that any activity, even the visits from her closest family, tired her. Her asthma has become so severe and she has become so nervous that the case was "temporarily" closed in home teaching. (Closing a case in home teaching means that the client is believed to be temporarily or permanently unable to profit from the home teaching services which are, therefore, temporarily or permanently discontinued. Other services by the agency, such as casework, may continue or even become intensified.)

It is worthwhile to note that, in spite of this client's extreme physical disabilities, the home teaching services were not completely unproductive. Mrs. Z. learned a few simple and useful skills and she greatly appreciated the efforts by the home teaching staff. Although she died only a few weeks after her case had been closed, she had made a courageous effort to live as an independent and useful member of society in spite of all odds against her.

The case of Mr. D., age 78, who is learning again how to write and type.

The client lives with his wife in a rented, second-floor apartment of a two-family home, located in a middle-class residential neighborhood. He is a retired credit correspondent and seems to be in a comfortable financial position.

Mr. D. started losing his vision gradually due to senile macular degeneration and became legally blind during Spring, 1966. Since he had lost his sight, the client was afraid of walking and especially of climbing steps. He went downstairs backward and sometimes on his hands and feet.

Mrs. Myra Oryshkewych, the agency's case worker, was the first one to point out to the client the danger of such walking and to teach him how to walk downstairs forward by holding onto the rail and by placing both of his feet on each step. The human guide technique was also given.

Mr. D. was then referred for home teaching and the Principal Investigator contacted him. Mr. and Mrs. D. were both very friendly. The Principal Investigator wrote on the Running Record that the client obviously "enjoys being with people." While he exhibited considerable anxiety relative to his adjustment to blindness, he stated he wished to take use of any service that might aid him in retaining his independence and his masculine role and in counteracting his growing feelings of isolation.

The Principal Investigator mentioned to Mr. D. some special clubs for the blind and within weeks he belonged to the Sterling Club and to another group for the blind at the Jewish Community Center.

The home teacher easily taught the client how to use the script-writing board and also began instruction in typing -- two activities in which Mr. D. was particularly interested. He has a considerable amount of correspondence and earlier he had also enjoyed typing stories and poetry. Since he had, at that time, typed with two fingers only, the client had first to unlearn his old technique. Occasionally, he still slips into his old way of typing, although he cannot any longer see the keys. But he has been learning the proper method gradually and, in some eight months after the teacher's first visit, he was able to type poems which he knew from memory.

While served by the agency, Mr. D. has learned the elements of typing and the essentials in mobility training. He knows how to use the script-writing board, the talking book machine and a braille watch. He is an interested member of two social clubs where he made several new friends. He has several things on the agenda: learning how to read and write braille, re-learning small-scale gardening, attending picnics and campings for the blind at agency's Highbrook Lodge and, perhaps, joining a music appreciation and a drama group.

Although Mr. D. received only an overall letter grade of "C" from his home teacher (which suggests what a tough grader she is), it is easily apparent that he has greatly benefited from her home teaching services.

We see here a man who shows considerable tensions and anxiety, but also a very good self-control, most probably an orientation that lasted since childhood. He plans rationally, unlearns and learns with patience and perseverance, counteracts the dangers of isolation and alienation with conscious efforts at socializing, and has many plans for further enrichment of his life -- in spite of physical darkness which involves him in his late seventies.

* * *

The preceding case histories, although brief and incomplete, strongly suggest the importance of earlier socialization. One could, with only minor qualifications, quote "Today's Chuckle," as published in The Cleveland Press of May 29, 1969: "Old age is like everything else: to make a success of it you've got to start young." Or, in the words of Frohlich: "... our latest adjustment strongly depends on the richness and the satisfaction we have achieved before we reach old age. It depends on how well we have matured and how well we have reaped the fruits of our maturity in our relations with our spouses, our children, and our friends. It depends on how well we have achieved emotional security, independence, and the satisfactions of various interests and activities which go with maturity. With better mental hygiene through our earlier life, the problems of old age will be minimized."[5]

These observations must, of course, be considered in conjunction with an important qualification, namely, "other things being equal." As we shall see in Chapter IV, variables, such as advancement in age or the number and kind of disabilities, are frequently significantly associated with the learning process and attitudes of the geriatric blind. Yet, when you have several persons who are similarly advanced in age, or similarly plagued by disabilities, their previous socialization and adjustment patterns play a crucial role in how they adapt to the problems of old age and blindness.

12. Closing a Client in Home Teaching

A client was closed in home teaching when his home teacher felt that he could no longer profit from her instruction. This assumption could be due to the fact that the client learned all the skills in which he was interested or which he was capable of learning; or it could be based on the teacher's conviction that the client was too senile, too maladjusted, too handicapped or too disinterested to profit from home teaching lessons.

Before the closing of a case, an understanding was reached between the teacher and the client (when the client was in good enough mental health) that the home teaching lessons were about to be completed. The home teacher frequently made any further necessary referrals, for instance, to group work services, camping, casework, etc.

As soon as possible after the last lesson, usually within a week or two, the Principal Investigator visited the client and gave him the same performance tests as on her earlier visit before the home teaching had started. A comparison between the two ratings was to show the relative effectiveness of the home teaching services. At the same time, the corresponding control group members were given identical tests to exclude the likelihood of factors other than home teaching in bringing about the changes in ratings.

In most cases, the second rating by the Principal Investigator was an experimental client's last contact with the home teaching project. Control group members, however, were free to join the experimental group after they had completed their function as controls. When they chose active home teaching services, their second rating as controls was automatically considered as the first rating of their new experimental role and the home teachers began to visit them as regular home teaching clients.

FOOTNOTES

1. Some excellent books on the subject are, Richard H. Williams, Clark Tibbitts and Wilma Donahue, Processes of Aging, New York: Atherton Press, 1963; Clark Tibbitts and Wilma Donahue (Eds.), Aging in Today's Society, Englewood Cliffs, N.J.: Prentice-Hall, 1960; Henry D. Sheldon, The Older Population of the United States, New York: John Wiley and Sons, 1958; Marvin R. Koller, Social Gerontology, New York: Random House, 1968. For a concise article on the dual problems -- and challenges -- of aging and blindness see Walter R. Boninger, "Aging and Blindness," The New Outlook for the Blind (A Special Issue on Aging and Blindness), June, 1969, pp. 178-184.

2. On origin of the case-study method see Pauline Young and Calvin Schmid, Scientific and Social Surveys and Research, New York: Prentice-Hall, 1939, p. 227. See also John Dollard, Criteria for the Life History, New Haven, Conn.: Yale University Press, 1935; and Gordon W. Allport, The Use of Personal Documents in Psychological Research, New York: Social Science Research Council, 1942.

3. Cf. Karen Horney, The Neurotic Personality of Our Time, New York: Norton, 1937; and Neurosis and Human Growth, New York: Norton, 1950. See also Donald H. Ford and Hugh B. Urban, Systems of Psychotherapy: A Comparative Study, New York: John Wiley and Sons, 1963.

4. Cf. E. V. Stonequist, The Marginal Man: A Study in Personality and Culture Conflict, New York: Charles Scribner's Sons, 1937; and Gordon W. Allport, Personality and Social Encounter, Boston: Beacon Press, 1960.

5. Moses M. Frohlich, M.D., "Mental Hygiene of Old Age," in Tibbitts and Donahue, op. cit., p. 61. Other studies have found some evidence that those who are well adjusted in their old age, tended to have happier family life in childhood. See, for instance, Suzanne Reichard, Florine Lioson and Paul J. Peterson, Aging and Personality: A Study of Eighty Seven Older Men, New York: John Wiley and Sons, 1962. See also Robert F. Peck and Herbert G. Richek, "Personality and Social Development: Family Influences," Review of Educational Research, December, 1964, pp. 574-584, and Giles Edward Gobetz, Learning Mobility in Blind Children and the Geriatric Blind, Cleveland: The Cleveland Society for the Blind, 1967, pp. 52-104. Such studies suggest that, although blindness means "death of many things," as discussed in Chapter I, the basic personality predispositions and orientations persist and continue to influence new adjustments.

IV. RESEARCH METHODOLOGY AND FINDINGS

13. Methodology

As mentioned in Chapter I, a Rating Sheet was developed in the project's preparatory phase during the first months of its existence.[1] This Rating "scale," while certainly not a perfect measuring device, was, as it befits a program in education, very similar to the grading system of our schools. Scores from "1" to "4," corresponding to various levels or grades of performance, were recorded, as each activity or skill was rated. The score of "4" represented the best performance or skill level, while "1" stood for the total inability or failure. Total scores for each individual were computed by means of simple addition. Total mean scores for groups or categories of clients were also prepared, as well as total mean scores for the major specific activities or skills which were tested.

Similarly, attitudes of clients were rated. These included attitudes toward the particular skills being taught, as well as the more general predispositions and orientations: feelings toward the Cleveland Society for the Blind, feelings toward the world, confidence in ability, etc.

The results again were quantified and, in addition to the mean scores on individual categories, the mean scores for all categories or "total mean scores" were obtained on before-and-after basis.

There were, of course, some variations in scoring. A woman, for instance, would be tested and rated in applying lipstick, while a man in tying his necktie, etc. Total individual scores would reflect an accumulation of points on all activities tested by means of the Rating Sheets.

This method seemed to be the best one available under the circumstances. It has the advantages as well as disadvantages which are observed in our general educational grading system, although the fear of a low "grade point average" was absent in our case since the clients did not know they were being graded.

Our scores, like the scholastic credit points or grade point averages, provided only rough approximations rather than fine and minute distinctions.

The questions of validity and reliability were dealt with by means of jury opinion and test-retest techniques.[2] Validity was established by consensus of experts from the fields of home teaching, rehabilitation counseling, social work, sociology, occupational therapy, and administration.

The computation of reliability coefficients between first ratings and second ratings for the control group (which corresponded to test-retest technique, with no intervention in-between) was used as the chief means for establishing the reliability of ratings. The reliability coefficient on total attitude ratings was .83 and that on total ability ratings .89. In a limited number of clients where comparable scores by the Principal Investigator and the home teachers were available, a number of correlations between the Principal Investigator's scores and the home teacher's scores were also computed in summer, 1967, when research help was available for a short time. All such correlations were found to be in .80's and .90's. They add additional weight to the reliability of ratings.

14. Principal Investigator's Ratings of Skills and Attitudes for All Newly Blind Clients

The maximum number of experimental newly blind geriatric clients for whom the necessary ratings were available was 132. In some computations, when a needed score was not ascertained or properly recorded, the frequency was somewhat lower, although never below 126 for the total number of the experimental newly blind clients.

Since the scoring centered on the demonstrated skills or abilities on one hand and attitudes or predispositions on the other hand, correlations between the two sets of scores were first computed. The correlation coefficient for total individual attitude scores and total individual ability scores computed from the first rating by the Principal Investigator was .77, while the corresponding correlation for attitude and ability scores of the second rating was .88.

This finding is, of course, in the expected direction, although the causal sequence cannot be established. It could be that good attitudes produced good abilities or higher skills. It could also be that higher performance ability or skills produced better or more optimistic attitudes. The authors are inclined to believe that there was actually an interplay in both directions, i. e., a poor attitude contributed to a lower ability performance level, while a low performance level reinforced poor attitudes, and vice versa with high-rating clients. Just as in the case of teachers and professors at schools, the objectivity of ability ratings could have been somewhat influenced by the performer's attitudes, and the level of performance might have somewhat influenced the investigator's appraisal of the client's attitudes, although this biasing factor, if it existed at all, was probably relatively unimportant. If a client was, for instance, found to be unable to thread a needle, to dial a telephone number or to peel a potato, he was rated "1" on all these skills, regardless of his optimistic or pessimistic attitudes. Bias, if it existed, might have been greater in ratings of attitudes.

The most crucial question for our demonstration research, of course, was whether there were any significant changes in the attitudes and in skills of the newly blind experimental clients between the first ratings (taken before home teaching had started) and second ratings (taken immediately after home teaching was completed). The answer is confidently affirmative. Statistically significant improvements were found in total attitude ratings ($t=2.01$, $P<0.05$) and in total ability ratings ($t=4.39$, $P<0.01$) for the total newly blind experimental group, while no significant differences developed in the control group.

Thus, speaking of the total success of the home teaching project in most general terms, it can be said that both the attitudes and the skills of the newly blind geriatric clients who had received the home teaching services showed a significant improvement as a result of these services. Statistical tests indicate that this improvement could not have been due to any chance factors, but can be ascribed, with a great deal of confidence, to the home teaching intervention.

15. Principal Investigator's Ratings of Skills and Attitudes by Special Categories of Clients

Do the clients differ, and if they do, how do they differ in their attitudes and abilities in terms of age, sex, race, duration of blindness, living arrangements and number and kind of disabilities other than blindness? The findings on each mentioned category are presented on the pages that follow.

a. Differences by Age

Small negative correlations were found between the age of clients and their total attitude and ability ratings. Specifically, the following correlations were found: age of clients and their total first ratings on ability or skills, r= -.21; age of clients and their total second ratings on ability, r= -.25; age of clients and their total first ratings on attitudes, r= -.22; and age of clients and their total second ratings on attitudes, r= -.28.

It ought to be remembered that these findings hold true only for the age category of 60 and over and the relationship could be entirely different if other age categories were included. Our age range was 37 years, with the youngest newly blind experimental clients being 60 years old, while the oldest client was 97 years old; the mean age was somewhat over 76 years, with the standard deviation from the mean being slightly over 8 years.

With these precautions underscored, we can say that age does have a noticeable, although relatively slight negative influence on the attitudes and abilities of the clients. (All correlations are negative and all in the .20s). Thus, while the scores tend to fall as clients become older, this deterioration in attitudes and skills is very small and inconsistent and is counteracted by so many exceptions that differences in age alone should not be considered a very important factor in attitudes and performance and learning potential of the geriatric blind.

The practical implication of these findings on age is that older clients should never be written off or excluded from the home teaching projects as necessarily unmotivated, or incapable of learning in home teaching or similar programs. The negative tendency of their advanced age alone is too slight and too inconsistent to justify age-based discrimination in home teaching and similar programs.

b. Differences by Sex

Our next question was whether males and females of the experimental group differed significantly in their attitudes and ability to perform on various tasks which were taught by the home teachers. The findings showed considerable differences by sex, with females scoring significantly better than males on first as well as on second attitude and ability ratings. Significance of the difference between two means was established on 0.01 levels on all comparisons, i.e., on the first attitude and the first ability ratings, as well as on the second attitude and the second ability ratings the total mean scores of females were significantly higher than the total mean scores of males. Such higher showing could have occurred by chance only once in a hundred times or less often. Thus, superiority of female scores over male scores has been clearly established. [3]

One should be very careful not to read too much into these findings. They demonstrate nothing about biological or personality differences between the sexes in general. All that these findings mean is that female clients received and probably earned statistically significantly superior scores on attitudes and skills as rated by the Principal Investigator.

We know nothing about the associated factors which might account for these higher ratings. The investigator's and the home teacher's sex (both were females) could have facilitated rapport and contributed to better attitudes and better performance among the female clients. The skills being rated might have been closer to female "areas" of liking and competence than to the interests of males. A breakdown of scores by specific skills could perhaps shed some light on this possibility. Unfortunately, budget and time limitations prevented us from exploring this possibility. Possible unconscious factors could have influenced the Principal Investigator to have been somewhat more lenient or optimistic in her rating of female clients, etc.

Whatever the contributing or biasing factors, there is no reasonable doubt, however, that in such areas of home teaching of the geriatric blind as were being offered in this demonstration project the attitudes and skills of women boasted significantly better scores than those of men.

c. Differences by Race

Among the newly blinded geriatric clients scores were available for 104 whites and for 28 Negroes. In all instances, Negro clients scored significantly higher than whites. They started out with better attitudes, performed better in skills which were tested before the home teaching lessons were given, and maintained significantly superior scores in the areas of attitudes and skills also on completion of the home teaching services.

As in the case of sex, no generalization beyond the score levels can be made. It can only be said that in the home teaching skills which were rated, as well as in their rated attitudes, Negroes were clearly superior and this superiority was in all instances statistically significant on the 0.01 level, i.e., it could have occurred by chance only once or less often in a hundred times.

The interpretation of this superiority can be only highly hypothetical. Negroes may have been more appreciative or grateful than whites for the attentions which they received from white project personnel (if and when they knew of the Principal Investigator's and, later, of the home teacher's race). They may have simply been more stimulated or encouraged by any kind of attention from anybody which could have favorably influenced their attitudes, rapport and performance. They might have, due to earlier conditioning, developed a higher degree of self-reliance and independence in various self-care techniques which were being tested.

Whatever factors may be associated with the significantly better showing of Negroes than of whites in this home teaching demonostration project, our findings should help to dispel any negative attitudes or prejudices against clients of the Negro race as being "poorer learning materials." In our project, not only were they equal to whites; they were significantly superior to them.

d. Differences by Duration of Blindness

As shown in Chapter II, the maximum duration of blindness in the experimental group of the "newly blind" geriatric clients was ten years. The mode was one year or less, with two and three years following in that sequence.

Bearing in mind that we are speaking only of the geriatric clients sixty years of age or older who were blind no longer than ten years (in other words, who lost their sight after age 50), we tried to see if the duration of blindness was in any way associated with the initial attitude and ability levels.

No support was found in this group for the belief that those who were blind for a longer period of time would have by necessity developed better attitudes and higher levels of skills, especially in such vital areas of daily living as were rated by the Rating Sheet. First total ability scores show extremely small positive correlation with the duration of blindness (r=.09), and the correlation coefficient for the duration of blindness and total first attitude scores was .05.

It can, therefore, be concluded that in blind persons over 60 years of age there can be no hope that attitudes and skills will automatically improve with the passage of time. To the contrary, those who were blind for several years showed almost no tendency whatsoever to score better on either attitudes or skills than those who were blind only a year or two. Clearly, the geriatric blind need help if they are to make progress in their adjustment to old age and blindness.

For the purpose of comparison a small group of eleven adventitiously blind persons, aged 44 to 81, who had been blind for an average duration of over 40 years (duration of blindness between 17 and 53 years) was also exposed to the home teaching services. Although the findings are, because of the small size of the group which may not be representative, very tentative, they may nevertheless be worth quoting. In this group, there was a clearly noticeable negative correlation between the duration of blindness and the total first rating ability scores (r=-.55), while the corresponding correlation between the duration of blindness and the first total attitude ratings was -.33.

Yet, the eleven clients showed significantly higher scores on all ratings than the newly blind geriatric clients. We can only hypothesize that those who became blind while still relatively young have made a better adjustment to blindness in their young years both on the level of skills as well as in their general attitudes. Thus, they surpass the newly blind geriatric clients who became blind late in life. Yet, after having reached a higher level of adjustment, no further progress was made in later years and some slight deterioration probably began late in life which accounts for the negative correlation of attitudes and ability with the duration of blindness.

Two additional findings should be noted. First, the eleven clients who were blind for a relatively very long time, showed no significant improvement whatsoever on either attitude or ability ratings as a result of the home teaching services (but the newly blind geriatric clients did).

Secondly, a very limited amount of follow-up ratings (third ratings taken at least six months after a case was closed, performed on 28 newly blind experimental clients) showed a drop in ability and attitude ratings with regard to the corresponding second ratings scores which, however, was not significant, and third ratings were still significantly higher than first ratings.

It thus seems plausible that those who became blind while not yet advanced in age, made superior adjustment, even entirely on their own, than the newly blind geriatric clients, but with the passage of years, their attitudes and skills deteriorated slightly although as a group they still surpassed the newly blind geriatric clients.

On the other hand, those persons who become blind after they are fifty years old or older remain on the relatively same -- somewhat lower -- attitude and ability level (reached apparently during the first year of blindness) regardless of the increasing duration of blindness, although home teaching services (and probably some other intervention strategies[4]) can significantly improve their attitudes and skills in a relatively short time.

e. Differences by Living Arrangement

Several living arrangements were found among the geriatric blind and, in many instances, there were significant differences among categories of clients by living arrangements.

Those clients who lived alone and had no arrangements for outside help of any sort (with the exception of home teaching), scored significantly higher than all other categories on the first ability ratings (all differences were significant on the 0 01 level); these clients also continued to manifest the highest degree of superiority in ability or skill tests in their second ratings. Their total mean ability score on the first rating was 64.57, as compared to 60.29 for those living alone but having arrangements for some help; or 57.83 for those living with spouse; 56.29 for those living with their children; and only 38.62 for those living in institutions. Second ability mean scores were as follows: 67.03 for those living alone with no help; 60.64 for those living alone but receiving some help; 59.55 for those living with spouse; 59.48 for clients living with their children; and 42.62 for those living in institutions.

Similarly, those living alone and having no outside help rated significantly higher than all other categories on their total first attitude ratings, as well as on the second attitude ratings. In all instances, their superiority was significant on the 0.01 level.

The first ability ratings of those living alone but receiving some outside help were significantly inferior to those living alone and receiving no help, but superior to those living with spouse, with child or in institutions ($P<0.01$).

The second ability ratings of those living alone with some help were significantly inferior to those living alone with no help, and significantly superior to those living in institutions, but not significantly different with regard to other categories.

First attitude ratings of those living alone with some help were significantly inferior to those living alone with no help, but significantly superior to those living with spouse, living with child, and living in institutions. All these differences were significant on the 0.01 level.

Second attitude ratings of clients living alone and receiving some help, while significantly inferior to those living alone and receiving no help, were significantly superior to the scores of clients living with their children or in institutions, but were not significantly different from those clients living with spouses.

Clients living with spouse were significantly superior on first ability ratings only to clients living with child or in an institution, and on second ability rating only to clients living in institutions. They were significantly superior to both of these categories also on first attitude ratings, but only to those living in institutions on the second attitude ratings.

Thus, in general it can be said that attitudes and skills were best for clients who lived alone and had no help; second best for those who lived alone and had some help. A position in the middle was held by those who lived with their spouses. Next to the bottom were those living with their children and the lowest on both attitude and ability ratings were clients living in institutions. Most of the differences were significant on the 0.01 level.

The interpretation of these findings can only be tentative. It is highly possible that pre-selection factors are at work, although one cannot exclude other possibilities which could account for some of the differences. It is possible that those who live alone chose this arrangement precisely because of their pre-existing superior predispositions and skills, while those with the lowest attitudes and skills escaped to the security of various institutions.[5]

Those living with children may be relatively more dependent personalities than any other category, with the possible exception of the institutionalized clients which would explain their second-lowest position.

Those living alone, although receiving some help, are probably the second most independent and "self-sufficient" group, hence second from the top on all total attitude and ability ratings. Those living with spouse probably exemplify all personality types -- independent, dependent and those in-between -- which would help to explain their position in the middle.

Alternative explanations in terms of social support, encouragement, etc., although they may explain several individual cases, could not satisfactorily explain the fact why those living alone with no help or with some help were actually superior to those living with spouses or children.

One would wish to examine other concomitant factors, such as possible age and disability differences between the living arrangement categories, but time and budget limitations preclude such analysis at the present.

The category of those clients living with relatives consisted of only three persons and was excluded from analysis for this reason.

With regard to progress made during the home teaching period, the following groups showed a significant improvement on total second ability ratings as compared to the corresponding first ratings: clients living alone with no help; clients living with spouse, clients living with children, and clients living in institutions. All these changes were significant on the 0.01 level. Clients living alone but receiving some help started out with the second highest total ability score, but made no significant progress in the area of skills during their home teaching involvement. What prevented this particular category from making progress is not clearly apparent. It may be possible that the members of this category are highly independent and do well in areas which they consider "appropriate" to or consistent with their self-concept, which may account for their relatively high scores. It may be that they also try to get help in selected areas which they consider "inharmonious" with their self-concept and they therefore resist any learning in these areas which could make the total significant improvement unlikely. Apparently, they exemplify the most selective "getting-of-help approach" when compared to those living with spouses and children or in institutions.

As for the ratings of total attitudes, the following categories made significant progress during the home teaching period: those living alone and receiving no help, those living with their spouses and those living in institutions. Clients living alone and getting some help actually represented a deterioration of attitudes, although not a statistically significant one. It could be that they have resented the offers of help on any terms other than their own. Also clients living with their children showed an extremely small and statistically insignificant drop in their attitude ratings. In all probability, their attitudes remained unchanged. Perhaps they depended on their children to the extent that others could not significantly influence their attitudes. While the fact that the institutionalized clients who were tentatively classified as those most dependent did significantly improve their attitudes might at first glance contradict our hypothetical explanation of no significant attitude change in clients living with their children, there may be an important difference accounting for the attitude improvement of the institutionalized clients. Unlike clients living with children, they were dependent on impersonal, probably secondary-group contacts. The visiting home teacher perhaps made them feel as "someone special" and could have conceivably raised their attitudes through her services.

As indicated before, many differences by living arrangements are statistically significant, i.e., they actually exist and are not due to chance. The interpretation of the direction of causal relationships is, however, entirely tentative, since it has not been in any way proven by our research.

"The general atmosphere was that of a friendly, constructive and warm relationship. ..." Here, Miss Johnson teaches a client how to operate a talking book machine.

f. Differences by Number of Disabilities Other than Blindness

As shown in Chapter II, clients were also classified into categories based on the number of their disabilities other than blindness. The designation "disabilities other than blindness" may be a more desirable one than that of "secondary" disabilities, since, in some instances, some disability other than blindness may be primary and blindness itself only secondary in its disabling effects.[6]

Clients with one, two and three or more disabilities other than blindness were significantly inferior to clients with no disabilities other than blindness on all total attitude and ability ratings, before as well as after the home teaching experience. All differences were significant on the 0.01 level. Similarly, clients with only one disability other than blindness were significantly superior on all ratings to clients with two or more disabilities, again always on the 0.01 level. However, when clients with two disabilities were compared to clients with three or more disabilities other than blindness, no significant differences were found on any of the total ratings, whether in the area of attitudes or of skills.

It can, therefore, be said that disabilities other than blindness have a negative effect on the home teaching clients. Clients without such disabilities have significantly better attitudes and demonstrate a higher level of skills than clients with disabilities. Clients who have only one disability other than blindness show significantly poorer ratings than those with no disabilities, but significantly better ratings than clients with two or more disabilities other than blindness.

Here, however, the significant differences stop. When we compare first ability ratings of clients with two disabilities other than blindness with first ability ratings of clients with three or more disabilities other than blindness, we find no statistically significant differences. The same holds true for comparisons of first attitude ratings, as well as for comparisons of second ability ratings and second attitude ratings.

Clients with no disability other than blindness started out with the highest ability and attitude levels and still managed to improve their skill levels as a result of the home teaching services, although they showed no significant improvement on their attitude scores. Clients with one and two disabilities other than blindness improved both their ability and their attitudes as a result of the home teaching process, while clients with three or more disabilities showed no significant improvement in their ability and attitudes due to the home teaching services.

Our findings suggest that, generally speaking, a higher number of disabilities tends to be associated with lower ability and attitude scores, although the significant difference stops once we reach two disabilities. Similarly, the learning potential which starts at a much higher level with clients who suffer from no disabilities tends to decrease as the number of disabilities increases. Clients with three or more disabilities other than blindness could no longer significantly improve their ability and attitudes as a result of the home teaching services such as were offered by the Cleveland Demonstration Project.

g. Differences by Kinds of Disabilities

There were also important differences among clients by categories based on kinds of disabilities. Only the most frequently found disabilities were examined.

A glance at the first total ability ratings shows that the highest first total ability ratings (after no-secondary disability clients) went to blind clients suffering from diabetes ($\bar{X}=58.55$). Next came heart-condition clients ($\bar{X}=57.39$), with arthritis clients having practically identical scores ($\bar{X}=57.38$). At the very bottom were stroke victims ($\bar{X}=53.38$) and slightly above these, the hearing-loss (or deaf and hard-of-hearing) clients ($\bar{X}=53.67$). Surprisingly, arthritis, heart condition or diabetes do not have a negative impact on attitudes and abilities of the home teaching geriatric blind clients equal to that of the loss of hearing or stroke.

If we turn our attention to progress made between the two ratings, we find the most significant improvement in the area of skills (after the no-secondary-disability clients) in the category of diabetic clients ($P<0.01$), followed by the category of the hearing-loss clients ($P<0.05$), while arthritis, heart condition and stroke clients, on the whole, have not significantly improved their skills as a result of home teaching services. (This does, of course, not exclude the possibility of some individual improvements, but refers only to the central tendency of the whole category.)

Total mean attitude scores again showed significant improvement among the hearing-loss and diabetic clients ($P<0.01$), while there were no significant changes in attitudes among arthritis, heart-condition and stroke clients.

Thus, while among clients with various disabilities other than blindness, the hearing-loss clients started in the project at the lowest score level in the area of both attitudes and skills, and the diabetic clients started out with the highest total mean scores in both areas, both these groups showed significant improvement in attitudes as well as in performance ability as a result of the home teaching services. No significant changes in either attitudes or skills were found in other most prevalent disability categories, arthritis, heart condition and stroke. Granting the possibility and the probability of individual exceptions among the latter clients, the categories as wholes show no promise of improvement as a result of the home teaching services such as were offered in our demonstration project.

As far as the kinds of disabilities are concerned, our research then suggests good improvement potential with clients suffering from no serious disability other than blindness, and with clients who have either diabetes or hearing loss, or even both of these. Clients with other major disabilities are, generally speaking, not likely to be positively affected by a home teaching approach such as was used in our demonstration study. Obviously, other more intensive techniques should be tried with them.

Two cautions must be emphasized: there will always be exceptions which, because of extraordinary personality and character traits or for some other reason, will defy this tentative rule; secondly, our findings establish only a tentative rule and, like all other findings, should be confirmed by replication studies before being wholeheartedly accepted as a clearly demonstrated fact.

Knowledge is being gained painfully and in small steps rather than by leaps.

h. Ratings of Specific Skills

As stated earlier, the total ability or skill ratings were in fact summations of scores received on various specific skills, namely personal grooming, communication, cooking, homemaking and leisure time activities.

What were the findings on each of these skills (each of which, in turn, included several activities which were rated on before-and-after basis)?

A comparison of first and second ability ratings shows significant improvement for all rated skill categories on the 0.01 level, with the exception of leisure time activities in which both scores were practically identical and no significant changes occurred. The improvement was highest in communication skills, followed by home-making skills, cooking and personal grooming, in that order. This is in line with the impressionistic reports by the Principal Investigator and both home teachers who repeatedly reported that clients were generally most anxious to learn communication skills and their learning was most impressive in this area.

16. Home Teachers' Ratings

Immediately after his appointment to the project staff, the senior author suggested that home teachers, too, should rate each skill or ability of their clients at various intervals and assign each client also an over-all rating score or grade at least at the end of his home teaching experience. Letter grades A, B, C, D and F (which can easily be transformed into numerical scores) were felt to be most appropriate for this purpose.

Unfortunately, this grading system, started only in the second year of the project, could never be completely developed. Over-all grades for each client were usually reported once every four months for purposes of progress reports, yet even in these reports many grades were missing. Grades on specific skills were even more incomplete. It is possible that additional record keeping was consciously or unconsciously resisted by teachers. Being blind, they might have also been afraid that their "minute" appraisal would not always be fair to clients. It may be that, being just out of school, they were much more interested in teaching useful skills than in grading. It could be that the research was at fault by not providing proper grading cards at the very beginning of the project or at least simultaneously with the recommendation concerning the introduction of the grading system.

Be this as it may, the grades on specific skills are too incomplete to allow a meaningful analysis. Over-all grades on clients were collected for the purposes of progress reports and, while also not completely satisfactory, lead to the following observations:

(1) Out of a total of 127 final over-all ability grades which the home teachers assigned their clients and which we could collect from their records, 15 were A's, 40 B's, 53 C's, 17 D's and 2 F's. Stated in percentages, 12 per cent of the clients were graded as A students on their over-all learning of skills; 31 per cent were B students, 42 per cent C students, 13 per cent D students, and less than 2 per cent F students or complete failures. The over-all project level was on the "C plus" level.

(2) Teachers' grading, although incomplete, nevertheless supports the ratings of the Principal Investigator. According to both, the home teaching project was a success.

(3) During the summer of 1967, when an assistant was briefly available, a few correlations of the scores by the Principal Investigator and the corresponding over-all grade scores by the home teachers were computed. All coefficients were in the .80's and .90's, adding weight to the reliability of findings.

17. Reactions from Clients, Their Relatives and Friends

Although some clients were difficult to reach and a few rejected the home teaching services (see Chapter II), the Principal Investigator, as well as both home teachers, managed to establish a satisfactory working rapport in a large majority of cases. While some appointments were cancelled, rejections and cancellations in all probability did not exceed the proportion of absenteeism in college classes.

Although no exact statistics are available, nearly all clients were reported to have been pleased with the home teaching services and grateful for the friendly visits by the Principal Investigator and the home teachers.

In numerous cases, blindness of the home teachers was a definite asset in their ability to reach the clients and to raise a wavering client's self-confidence. Sighted staff members would occasionally be reminded that it was easy for them to talk how a blind person could learn to do this or that or how he should feel. Let a sighted person just close his eyes and see how helpless he would be! . . . But listening to a blind home teacher and getting useful demonstrations from her allowed no easy way out.

Not infrequently, blind clients, and also their relatives and friends, developed a great admiration for the blind home teacher. In most cases, clients seemed to be genuinely glad when the home teacher paid them a visit and grateful for her lessons and friendship.

The Principal Investigator, as well as the home teachers and the directors of the Cleveland Society for the Blind, received several letters and telephone calls, expressing the appreciation of the clients, their spouses, children or other relatives, or even of friends, for the home teaching services.

During the three years of demonstration, there were only two known complaints, both from chronic complainers who also complained about everyone else in their families and about neighbors, etc. A maladjusted old lady at first refused the services, saying that she could manage perfectly well on her own but later she complained that the home teacher failed to see her; another client tended to forget everything, including the scheduled appointments, but occasionally complained of home teacher's "constant mistakes."

The general atmosphere, established only impressionistically, however, was that of a friendly, constructive and warm relationship, which was greatly appreciated by nearly all clients and often also by their relatives, neighbors and friends. Numerous regrets were voiced when a case had to be closed in home teaching. Statements such as, "You made my life so much easier," or "I have never dreamt that I could possibly learn all this," can frequently be found in letters of appreciation or on the case records.

Being surprised at the ability of the blind to perform is, of course, not unusual. Not only clients, but many sighted persons, too, are repeatedly surprised at a blind person's ability to thread a needle, sew by hand or machine, peel potatoes, write letters, sign checks, play cards, tell time, iron clothes, roast a steak, or bake cookies and serve them with hot coffee or tea.

All these skills, and many others, were effectively taught by our totally blind home teachers to scores of their newly blind geriatric clients.

V. LIMITATIONS AND CHALLENGES OF THE PROJECT

In many regards, this was a pioneering large-scale home teaching study of the newly blind geriatric clients, perhaps the most comprehensive and inclusive one to date. It represented a unique challenge for all staff members. It goes without saying that it suffered a number of limitations.

(1) The staff was limited in what it could do by the budget and time limitations. Initial stages had to be planned without the benefit of research specialists, by practitioners who were already overburdened with many other duties. Home teachers had to concentrate on the most essential home teaching services, while their record keeping left much to be desired. Time Sheets and consistent home teacher's grade records are severely missed for purposes of analysis.

(2) Since the staff and resources were limited, the project was faced with the dilemma whether or not to devote sufficient time to clients who apparently gave relatively little promise of profiting from the home teaching services. This at times led to what could be considered a certain lack of persistence in "selling the program" to the least motivated or most reluctant clients. If richer resources were available, one would want to invest an extraordinary effort into the work with the apparently most hopeless clients. Many direct and indirect techniques could be experimented with, including the support by relatives, friends, pastors or other in-betweens; preparation of the home teaching atmosphere by means of special tapes, records, or other devices; music therapy; variation in personnel, environments, etc.

(3) While some of the potentially very useful research data were never systematically collected (e.g., time-sheet data, pertinent background information, possible personality and I.Q. tests, self-concept ratings,[1] etc.), some of the available materials could not be utilized in this study because of budget and time limitations. An intensive analysis of specific skills and specific attitudes would be very desirable, but could not be attempted at the present time. Analysis of possible differences in achievement by marital status had to be omitted. Similarly, a thorough content analysis of all records would undoubtedly shed new valuable light on the subject, but it would require full-time services of a research specialist on this topic alone, while the Society, like most other service

agencies, has frequently been forced to spread part-time services over several projects. These limitations are becoming challenges for future program development and research.

Thus, when one looks at a project in terms of the ideals which could be attained under optimum conditions, nearly all service projects and demonstration studies leave much to be desired. Our project certainly is no exception. However, when we think of the many clients who, in spite of a number of limitations, were considerably helped in several ways -- helped in areas vitally important to themselves, their families and perhaps even to society at large, and when we contemplate on all those aspects which were not known before but are known or better understood now as a result of an action and study project, then we have a just cause for constructive optimism.

It is only when we are capable of embracing and keeping alive such constructive optimism that we can hope to go on developing, implementing and studying various programs and approaches which will more and more truly and fully benefit the geriatric blind and other groups which may need our help and in turn make the concerned human society in which we live and work more and more truly and fully human.

FOOTNOTES

1. The authors believe that a client's self-concept is probably one of the most important variables affecting his adjustment and learning, but had practically no data on this variable for the study population. For an excellent bibliography on self-concept see Wilbur B. Brookover, et al., Self-Concept of Ability and School Achievement, II, East Lansing, Mich.: Bureau of Educational Research Services, Michigan State University, 1965, pp. 215-219.

VI. CAPSULE FINDINGS

While most findings have been presented and discussed in Chapter IV and summarized in tabular form in Appendix II, a brief descriptive summary of the most relevant findings is here presented for the benefit of those busy researchers and practitioners who might find it difficult to read and carefully digest the entire study.

* * *

The Cleveland Demonstration Project in the Home Teaching of the Geriatric Blind has demonstrated that clients over sixty years of age who had been blind less than ten years can, on the whole, successfully learn various home teaching skills, such as activities of daily living, personal grooming, communications, cooking, sewing, and various other tasks. In general, the totally blind home teachers were able to bring about a significant improvement in the attitudes and skills of their clients.

* * *

Attitudes toward environment and life in general are strongly linked with one's ability to master various home teaching skills. The better the attitudes at the start of the project, the better the performance skills at that time. The positive correlation between attitudes and the skill levels achieved was even higher at the end of the project, with those having good positive attitudes scoring relatively high on various home teaching skills and those characterized by poor or negative attitudes scoring relatively low on performance or ability tests.

* * *

Within the age range which was thoroughly studied in this project (clients between 60 and 97 years of age), the age factor was relatively unimportant. There were only relatively low negative correlations between age and attitudes, as well as between age and skill or ability scores (all correlations in -.20's), suggesting that, although older clients tended to manifest slightly poorer attitudes and achieve slightly lower scores on their performance tests, both before and after the home teaching services, the differences were very small and were counteracted by so many exceptions that age alone should not be considered an important factor in determining the eligibility for home teaching projects or the likelihood for a client's success in such programs.

* * *

Generally speaking, female clients were superior on attitudes as well as on skills to male clients and Negro clients were superior on all tests to white clients. Although males as well as whites, too, demonstrated their ability to profit from the home teaching project, the above findings may be useful in counteracting possible preconceptions about "old women" or Negroes being poorer risks in a learning experience such as the home teaching project.

* * *

Among clients aged over 60 and blind up to ten years, those persons who were blind for several years hardly showed any better attitudes, or performed any better on the achievement tests, than clients blind for only a short period of time. Thus, for clients over sixty there is very little hope that they would, alone and without skilled help, improve their attitudes and their skills, regardless of how many years may have elapsed since they had first lost their sight. While those who became blind earlier in life might, to a certain extent, learn by themselves and score relatively better on attitudes and on skills even in the absence of skilled intervention, the geriatric clients of over sixty years of age need skilled help in order to improve their attitudes and performance skills.

* * *

Significant differences were found between categories of clients by living arrangement. (This does not necessarily mean that it is the type of living arrangement which predisposes a client to perform better or worse, since the living arrangement may itself reflect earlier predispositions.) Generally, those clients who lived alone and had no outside help (excepting the home teaching project) scored highest on attitudes as well as on skills. Those living alone and having some outside help scored next highest. Clients living with their spouses were in the middle. Clients living with their children were near the bottom, while the attitudes and skills of the institutionalized clients were the lowest of all.

* * *

The following living-arrangement categories showed a significant improvement in skills as a result of the home teaching services: clients living alone with no help, those living with their spouses or with their children, and clients living in institutions. Those clients who lived alone but had arrangements for outside help failed to improve their skills as a result of the home teaching experience.

* * *

The following categories showed a significant improvement in their attitudes as a result of home teaching: clients living alone with no outside help, clients who lived with their spouses and the institutionalized clients. Clients who lived alone and had arrangements for outside help and those who lived with their children failed to improve their attitudes during the home teaching project.

* * *

The number of disabilities other than blindness was significantly related to attitude and skill levels of the clients. Clients suffering from no disabilities other than blindness scored significantly better on attitudes as well as on skills than clients who suffered from additional disabilities. Again, clients suffering from only one disability other than blindness were significantly superior on all ratings to clients suffering from two or more additional disabilities. However, clients with two additional disabilities scored approximately as low on attitudes and abilities as clients with three or more additional disabilities. However, although clients with fewer than two disabilities other than blindness tended to start and end with significantly higher ability and attitude scores than clients with two or more disabilities, all clients with fewer than three disabilities showed a significant improvement on ability scores as a result of the home teaching services. The same was true with the improvement of attitudes, with the exception of no-disability-other-than-blindness clients who, while showing highest ability and attitude scores on all ratings, nevertheless failed to register a significant improvement in their attitudes as a result of home teaching. Generally speaking, only clients with three or more disabilities other than blindness are not likely to benefit from the home teaching services such as were offered by our project. Whether or not they could benefit from different, perhaps more intensive approaches, remains to be shown by future demonstration projects.

* * *

Focusing our attention on the progress made in the area of various skills as a result of the home teaching services, we find the most impressive progress among the clients suffering from no disabilities other than blindness. Diabetic and hearing-loss clients follow in that order. Heart-condition, arthritis and stroke victims, on the whole, made no significant progress in learning new skills or improving their previous skills as a result of the home teaching experience. The initial level of ability was not necessarily predictive of success in home teaching.

* * *

Only the diabetic and hearing-loss clients have significantly improved their attitudes during the home teaching project. Other disability categories, generally speaking, failed to show such improvement.

* * *

Considering specific rather than total ability or performance scores, we find that clients, in general, showed an improvement in their skills in all rated areas (i. e., personal grooming, homemaking, communications, and cooking), with the exception of leisure time activities. Progress made in the area of communication skills was especially impressive.

* * *

A review of grades given by the home teachers shows the following distribution: A's, 12 per cent; B's, 31 per cent; C's, 42 per cent; D's, 13 per cent; F's, 2 per cent.

* * *

The relationship between the clients and project personnel was, on the whole, a close, warm and positive one. Only six per cent of all persons who were invited into the project refused the home teaching services. Although many of the clients who had accepted the services were at first skeptical about their ability to profit from home teaching, a good rapport was established in a large majority of cases and there was a noticeable progress in attitudes and skills of most clients. Although the attitudes of spouses, children, other relatives and friends of the clients could not be systematically studied, the impression was that these persons, in nearly all cases, reacted favorably to the home teaching project and its personnel and were often surprised at what a client could learn in spite of his old age, blindness, and, not infrequently, additional disabilities.

* * *

As shown earlier, a minority of clients could not benefit in a measurable degree from the home teaching program which was offered by the Cleveland Demonstration Project. Other techniques should be attempted with the categories of unsuccessful clients.

* * *

In interpreting the above "capsule findings," one should bear in mind the desirability of replication studies, as well as the fact that all findings apply only to the entire categories of clients. Thus, they hold true for a given category as a whole, without denying the possibility or the probability of exceptions. The exceptions, however, do not exert sufficient weight to change the findings for a given category as a whole.

VII. IMPLICATIONS AND SUGGESTIONS FOR FUTURE PROJECTS

As our study has shown, the geriatric blind, if left to themselves, are not likely to improve their attitudes and skills with the passage of time since they first became blind. A longer duration of blindness does not per se mean that a geriatric blind person's attitudes and abilities, including his skills in the area of everyday living, are likely to be superior to those of the recently blinded old individuals. This finding strongly suggests that skilled intervention is necessary to facilitate a geriatric blind person's adjustment to life, to increase his independence and to lessen, at least to an extent, the burden which he imposes on his family, relatives or on society at large.

Obviously, then, home teaching should start as soon as possible after the onset of blindness and immediately after the client is able and willing to accept such services. In the light of our findings, the several years which may often elapse between the onset of blindness and the beginning of the home teaching services are completely lost to the client and represent an unnecessarily severe burden on his family, relatives, or society at large.

This means that efficient case-spotting techniques should be developed for early discovery of the aged blind clients. The techniques which have so far been used by the Cleveland Society for the Blind and other similar service agencies have been only partly successful. It follows that, with increasing numbers of the geriatric blind, more aggressive outreach strategies should be developed to reach the newly blind geriatric clients much earlier after the onset of their blindness. This would imply not only an intensification in the dissemination of information and education to the public at large, but also the development and implementation of efficient, systematic procedures to reach all professions and occupations which come into contact with the aged blind. Once such professions and occupations are effectively reached, universal (or as nearly universal as possible) case-reporting procedures should be developed on a cooperative basis.

Undoubtedly, systematic and controlled experimentation will be necessary to find out which of the many possible outreach strategies, or which combination of strategies, is most effective in reaching the maximum number of clients within the best possible limits in timing under certain specified conditions. Such development of optimum case-finding and case-reporting techniques would greatly benefit not only the aged blind and those who might otherwise be excessively burdened with their care, but also many other service categories where similar outreach techniques could be implemented with perhaps only a few minor adaptations.

The statistical trend mentioned earlier in this report, as well as earlier and more universal case-finding and case-reporting techniques, will, of course, considerably increase the number of known geriatric clients in need of home teaching services. It seems rather certain that, in spite of recent improvements in the number and quality of professionally trained home teachers, their supply is likely to remain far short of the actual demand for many years to come. Indeed, it is quite possible that the increase in the number of the geriatric blind will continue to be greater than the corresponding increase in the number of professionally trained home teachers. In any case, to satisfy the existing and future needs for home teaching services, new approaches will have to be developed.

In the absence of a sufficient number of professionally trained home teachers, it is proposed that we should begin experimenting with the blind home teaching aides. Here, the findings of our report are again of considerable relevance.

First, the fact that blindness of the instructor can be used as an asset in disarming the defenses of the client and in increasing his motivation to learn suggests the appropriateness of experimentation with blind home teaching aides.

Secondly, our study has shown that the instruction in relatively simpler skills is in greatest demand: telephone dialing, script-board writing, telling time, threading needles, identifying various items, operating the talking book machines, learning simpler mobility techniques, etc. Thus, the blind home teaching aides could be trained by professional home teachers how to teach these simpler skills. The professional home teachers could, in this way, use their knowledge in a much more efficient manner, while devoting the remaining time to direct instruction of more demanding skills, such as typewriting, braille, cooking and baking, machine sewing, etc.

Thirdly, our research also suggests the categories of clients which are likely to be more successful in home teaching, notably females, Negroes, those living alone with no help, those with no disabilities other than blindness, diabetics, etc. It would seem wise to experiment with the home teaching aides especially among the easier-to-teach clients, while, with the time thus saved, professional home teachers could give more intensive services to the harder-to-teach clients. Sexwise, it may also be suggested that male blind home teaching aides could be assigned to teach some categories of clients, with female home teaching aides given comparable assignments on matched controls to see what role, if any, can be ascribed to the sex of the home teaching personnel.

Fourthly, recent research suggests that, at least in the area of attitudes and simpler skills, non-professionals who are, by their background, social class, and general culture (or subculture), closer to their clients than the professionals, may become, after the appropriate short-term training, equally or more effective and influential in training of the same-level clients than their professional counterparts.[1] Most geriatric blind clients come from non-professional classes and are in need of learning relatively simpler skills. These facts speak quite convincingly for the advisability of experimenting with non-professional blind home teaching aides.

The experimentation with non-professional "in-betweens" could gradually be extended to interested and concerned relatives and friends of the non-institutionalized geriatric blind persons. In institutions, such as homes for the aged or gerontological wards of various hospitals, some appropriate staff member, such as an interested nurse, nurse aide or orderly, or perhaps also a volunteer, could also be trained in giving simpler lessons to the institutionalized geriatric blind.[2]

Our very limited research with the apartment group suggests the advisability of experimenting with this approach for certain categories of clients (those who are physically able to travel and for whom transportation can be provided, those whose self-confidence or "ease" could possibly be increased in a client small-group situation, etc.). Such clients could be taught at an agency's model apartment (as was the case at the Sight Center of the Cleveland Society for the Blind), or some other convenient neighborhood apartment could be accepted for such lessons when voluntarily offered by one of the clients, a volunteer or some other agency.

In certain instances, this "apartment approach" may prove to be a very effective alternative to the traditional home teaching practices. Some clients may learn better in small groups of client-peers than when alone with their home teacher.[3] They may also show greater willingness to use the skills thus acquired once the home teaching services are terminated.[4] These suggestions are derived from experiments in areas other than home teaching where competitive small group situations, or decisions supported by group discussions, proved to bring about superior results. They are, of course, offered only as working hypotheses to be tested in somewhat different situations with different categories of individuals. It cannot be denied, however, that the small apartment group with which we had briefly experimented in our demonstration project showed a remarkable improvement in attitudes as well as in the development of skills.

Greater involvement of a client's relatives, friends, neighbors, etc., in home teaching may also prove to be beneficial either for purposes of emotional support or for their use in the roles of teaching "in-betweens," at least with certain categories of clients and selected categories of potential "in-betweens." Furthermore, those relatives who are, for instance, reluctant to allow their blind charges to become more independent, could be invited to observe, or even to participate in the teaching process, whether at home or in the apartment experiment. Conversely, a client lacking self-confidence or reluctant to become more independent, may improve his self-concept and become more motivated to increase his independence after receiving stimulation and encouragement from his relatives or client-peers.

In summary, we can conclude that the home teaching demonstration project of the U.S. Administration on Aging and the Cleveland Society for the Blind has clearly shown that the geriatric blind clients are teachable, that their attitudes and skills (which failed to improve with the increased duration of blindness in the absence of skilled intervention) can significantly be improved by means of the home teaching services.

At the present time, it would seem imperative that the home teaching services be expanded to all geriatric blind persons who need them, first by systematically improving the case-finding and case-reporting techniques and, secondly, by developing and implementing new home teaching approaches, especially by means of the non-professional, short-term-trained, more easily available and less expensive blind home teaching aides who would teach simpler skills to the easier-to-teach categories of clients, and by experimenting with other possible home teaching "in-betweens" and also with such alternatives to the traditional home teaching practices as model-apartment or neighborhood-apartment small-group teaching situations.

According to all indications, the need for effective home teaching services will continue to grow in years to come. It is the task of every enlightened society to effectively cope with its current needs and to anticipate its future needs and be ready for them as they develop on a larger scale. It is hoped that the findings of this study, with the accompanying implications and suggestions, may contribute a small part toward our increased efficiency in coping with the problems and challenges of our growing geriatric blind population.

FOOTNOTES

1. See especially Arthur Pearl and Frank Riessman, New Careers for the Poor, New York: The Free Press, 1965. See also, Giles Edward Gobetz, Reaching the Unreached in Hough, Cleveland: CAY, 1966, pp. 52-72 ff; and the same author's Learning Mobility in Blind Children and the Geriatric Blind, Cleveland: The Cleveland Society for the Blind, 1967, pp. 53-61.

2. In the final report of its mobility demonstration project, the Cleveland Society for the Blind reported: "The most important result of this experimentation [in the nursing homes] was the finding that one or more nursing home staff members could effectively be trained to give any needed orientation and mobility training to blind geriatric inmates under the guidance and supervision of a professional peripatologist. This finding seems to be especially important in view of the widespread visual handicaps in nursing homes and homes and hospitals for the aged and in view of the shortage of professionally trained peripatologists." See Giles Edward Gobetz, Learning Mobility in Blind Children and the Geriatric Blind, Cleveland: The Cleveland Society for the Blind, 1967, p. 121.

3. Cf. J. F. Dashiell, "An Experimental Analysis of Some Group Effects," Journal of Abnormal and Social Psychology, 1930, No. 25, pp. 190-199.

4. Cf. Kurt Lewin, "Group Decision and Social Change" in Guy E. Swanson et al. (eds.), Readings in Social Psychology, New York: Henry Holt and Company, 1952, pp. 459-473. See also Lester Coch and John R. P. French, Jr., "Overcoming Resistance to Change," Human Relations, 1948, No. 1, pp. 512-532.

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APPENDIX

APPENDIX I

NAME________________________________ Date____________________

HOME TEACHING OF NEWLY BLIND GERIATRIC CLIENTS
Ability Rating Scale
AOA Project July 1966

1. PERSONAL GROOMING

Hair:	combing	1	2	3	4
Lipstick:	applying	1	2	3	4
Shoes:	polishing	1	2	3	4
Necktie:	tying	1	2	3	4
General Appearance:	(a) Clothing -- in terms of neatness	1	2	3	4
	(b) Personal hygiene -- in terms of cleanliness	1	2	3	4

2. HOMEMAKING

(over board

Ironing:	Set up board, plug in iron, run hot iron	1	2	3	4
Cleaning:	Table top	1	2	3	4
Sweeping:	Floor	1	2	3	4
Dusting:	Furniture	1	2	3	4
Threading:	Thread a needle	1	2	3	4
Sewing:	Sew on button	1	2	3	4

3. COOKING SKILLS

Using kitchen range:	(a) lighting top burner, judging heat	1	2	3	4
	(b) lighting oven, setting heat	1	2	3	4
Pouring:	(a) fill a cup with cold water	1	2	3	4
	(b) fill a cup with hot water from kettle	1	2	3	4
Measuring:	(a) fill a cup 2/3 full with dry ingredient (sugar or flour)	1	2	3	4
	(b) fill a cup 2/3 full of water	1	2	3	4
Spreading:	Butter on bread	1	2	3	4
Peeling:	Potato or apple	1	2	3	4
Slicing:	Potato or apple	1	2	3	4

4. COMMUNICATION SKILLS

Dialing a telephone yes____no____

Identifying coins yes____no____

Telling time by watch or clock yes____no____

Script writing: unable_____legible_____excellent_____

Operate radio or television: yes____no____

Operate talking book machine: yes____no____

5. LEISURE TIME ACTIVITIES

Play cards: ______________
Reading: ______________
Listen to radio or TV: ______________
Attend Golden Age Center: ______________
Attend Social Club: ______________
Attend movies: ______________
Eating in restaurant ______________
Enjoy a hobby ______________
Visit with neighbors ______________
Visit with friends ______________
Entertain friends or neighbors ______________
Attend Church ______________

COMMENTS:

Key for rating:

In terms of functioning --
1. = Unable
2. = Limited ability, needs help
3. = Good ability, assistance not needed
4. = Excellent ability

In terms of a value --
1. = Very poor
2. = Fair
3. = Good
4. = Excellent

APPENDIX I (Cont'd.)

NAME________________________________ Date____________________

HOME TEACHING OF NEWLY BLIND GERIATRIC CLIENTS
Attitude Rating Scale
AOA Project July 1966

1. FEELINGS TOWARD THE SOCIETY FOR THE BLIND

___Very resentful and bitter ___ Unable to determine
___Somewhat resentful and bitter
___Somewhat friendly
___Very friendly

2. FEELINGS TOWARD THE WORLD

___Hostile and antagonistic ___ Unable to determine
___Somewhat hostile and antagonistic
___Friendly but with reservations
___Friendly without reservations

3. CONFIDENCE IN ABILITY

___No confidence in ability ___ Unable to determine
___Little confidence in ability
___Have a degree of confidence in ability
___Highly confident of ability

4. USE OF BLINDNESS AS A BARRIER TO SATISFACTORY ADJUSTMENT

___Uses his blindness as a strong barrier ___ Unable to determine
___Uses his blindness to some degree as a barrier
___Does not use his blindness as a barrier with reservations
___Never uses his blindness as a barrier

5. FEELINGS ABOUT COOKING SKILLS

___Antagonistic, wants no part of cooking ___ Unable to determine
___Reluctant to learn and use cooking skills
___Somewhat interested in cooking
___Interested in cooking without reservations

6. FEELINGS ABOUT PERSONAL GROOMING

___ Disinterest -- who cares ___ Unable to determine
___ Reluctant to bother
___ Somewhat interested in being well groomed
___ Very interested in being well groomed without reservations

7. FEELINGS ABOUT HOMEMAKING

___ Not for me -- definitely not interested ___ Unable to determine
___ Reluctant to bother
___ Somewhat interested
___ Very interested

8. FEELINGS ABOUT LEISURE TIME ACTIVITIES

___ Definitely not interested
___ Slightly interested
___ Moderately interested
___ Very interested

9. FEELINGS ABOUT COMMUNICATIONS SKILLS

___ Not interested -- who needs it ___ Unable to determine
___ Only slightly interested
___ Moderate interest
___ Very strong interest

APPENDIX II

SUMMARY OF SELECTED STATISTICAL FINDINGS*

Table 13. Selected Correlation Coefficients for Major Project Categories

Population Category	Correlated Variables		Correlation Coefficient
Total Experimental	Attitude I**	Ability I	.77
	Attitude II	Ability II	.88
	Age	Ability I	-.21
	Age	Ability II	-.25
	Age	Attitude I	-.21
	Age	Attitude II	-.28
	Duration of Blindness	Ability I	.09
	Duration of Blindness	Ability II	.05
Experimental - Blind Over 10 Years	Age	Ability I	-.41
	Age	Attitude I	-.16
	Duration of Blindness	Ability I	-.55
	Duration of Blindness	Attitude I	-.33
Total Control	Attitude I	Attitude II	.83
	Ability I	Ability II	.89

* For discussion of findings, see Chapter IV.

** Attitude I refers to total mean scores on first (or before) ratings; Attitude II to the corresponding scores on second (or after) ratings.

Table 14. Significance of Difference Between Means Indicating Changes in Scores for Newly Blind Clients

Population Category	Variables Compared*				t-value	Probability
	First	Mean	Second	Mean		
Total Experimental	Abil. I	57.45	Abil. II	60.38**	4.39	0.05
	Att. I	22.80	Att. II	23.40	2.01	0.01
Cooking	Abil. I	19.91	Abil. II	20.76	13.07	0.01
Communication	Abil. I	9.52	Abil. II	10.21	26.67	0.01
Personal Grooming	Abil. I	12.21	Abil. II	12.48	9.96	0.01
Homemaking	Abil. I	11.54	Abil. II	12.56	22.70	0.01
Leisure Activities	Abil. I	4.21	Abil. II	4.20	0.12	N.S.***

* Means, *t*-values and probability levels are presented. Calculations were based on frequencies, means and standard deviations.

** Higher mean scores stand for better ability or attitudes.

*** N.S. =not significant.

Table 15. Significance of Difference Between Score Means for Newly Blind Clients by Sex

Variables Compared				t-values	Probability
Male	Mean	Female	Mean		
Ability I	53.15	Ability I	59.83	23.94	0.01
Ability II	56.12	Ability II	63.64	26.97	0.01
Attitude I	20.82	Attitude I	23.71	24.41	0.01
Attitude II	21.89	Attitude II	24.57	24.86	0.01

Table 16. Significance of Difference Between Score Means for Newly Blind Clients by Race

Variables Compared				t-values	Probability
White	Mean	Black	Mean		
Ability I	57.00	Ability I	59.07	18.20	0.01
Ability II	59.88	Ability II	62.46	7.39	0.01
Attitude I	22.35	Attitude I	24.50	15.25	0.01
Attitude II	23.08	Attitude II	24.64	11.82	0.01

Table 17. Significance of Difference Between Score Means for Newly Blind Clients by Living Arrangements

Variables Compared					
First	Mean	Second	Mean	t-value	Probability
Alone - No Help		Alone - Some Help			
Ability I	64.57	Ability I	60.29	7.51	0.01
Ability II	67.03	Ability II	60.64	8.81	0.01
Attitude I	25.31	Attitude I	24.29	3.32	0.01
Attitude II	25.80	Attitude II	23.86	6.28	0.01
Alone - No Help		With Spouse			
Ability I	64.57	Ability I	57.83	15.64	0.01
Ability II	67.03	Ability II	59.55	15.33	0.01
Attitude I	25.31	Attitude I	22.28	15.15	0.01
Attitude II	25.80	Attitude II	23.21	12.45	0.01
Alone - No Help		With Child			
Ability I	69.57	Ability I	56.29	18.61	0.01
Ability II	67.03	Ability II	59.48	14.14	0.01
Attitude I	25.31	Attitude I	23.03	11.40	0.01
Attitude II	25.80	Attitude II	23.00	14.74	0.01
Alone - No Help		In Institution			
Ability I	64.57	Ability I	38.62	53.95	0.01
Ability II	67.03	Ability II	42.62	36.54	0.01
Attitude I	25.31	Attitude I	13.38	46.24	0.01
Attitude II	25.80	Attitude II	16.85	35.80	0.01
Alone - Some Help		With Spouse			
Ability I	60.29	Ability I	57.83	3.19	0.01
Ability II	60.64	Ability II	59.55	1.23	N.S.
Attitude I	24.29	Attitude I	22.28	5.73	0.01
Attitude II	23.86	Attitude II	23.21	1.70	N.S.

Table 17. (continued)

Variables Compared				t-value	Probability
First	Mean	Second	Mean		
Alone - Some Help		With Child			
Ability I	60.29	Ability I	56.29	5.19	0.01
Ability II	60.64	Ability II	59.48	1.27	N.S.
Attitude I	24.29	Attitude I	23.03	3.63	0.01
Attitude II	23.86	Attitude II	23.00	2.46	0.05
Alone - Some Help		In Institution			
Ability I	60.29	Ability I	38.62	23.67	0.01
Ability II	60.64	Ability II	42.62	15.14	0.01
Attitude I	24.29	Attitude I	13.38	23.56	0.01
Attitude II	23.86	Attitude II	16.85	14.22	0.01
With Spouse		With Child			
Ability I	57.83	Ability I	56.29	2.75	0.01
Ability II	59.55	Ability II	59.48	.11	N.S.
Attitude I	22.28	Attitude I	23.03	2.80	0.01
Attitude II	23.21	Attitude II	23.00	.87	N.S.
With Spouse		In Institutions			
Ability I	57.83	Ability I	38.62	28.38	0.01
Ability II	59.55	Ability II	42.62	21.27	0.01
Attitude I	22.28	Attitude I	13.38	29.76	0.01
Attitude II	23.21	Attitude II	16.85	19.21	0.01
With Child		In Institutions			
Ability I	56.29	Ability I	38.62	24.92	0.01
Ability II	59.48	Ability II	42.62	19.33	0.01
Attitude I	23.03	Attitude I	13.38	32.49	0.01
Attitude II	23.00	Attitude II	16.85	20.57	0.01

Table 18. Significance of Difference Between Means Indicating Changes in Scores for Newly Blind Clients by Living Arrangements

Living Arrangement Category	Variables Compared				t-value	Probability
	First	Mean	Second	Mean		
Living Alone-No Help	Ability I	64.57	Ability II	67.03	6.74	0.01
	Attitude I	23.31	Attitude II	25.80	2.77	0.01
Living Alone-Some Help	Ability I	60.29	Ability II	60.64	.30	N.S.
	Attitude I	24.29	Attitude II	23.89	.29	N.S.
Living with Spouse	Ability I	57.83	Ability II	59.55	3.06	0.01
	Attitude I	22.28	Attitude II	23.21	3.78	0.01
Living with Child	Ability I	56.29	Ability II	59.48	5.20	0.01
	Attitude I	23.03	Attitude II	23.00	.13	N.S.
Living in Institution	Ability I	38.62	Ability II	42.62	4.56	0.01
	Attitude I	13.38	Attitude II	16.85	9.20	0.01

Table 19. Significance of Difference Between Score Means for Newly Blind Clients by Number of Disabilities Other than Blindness

Variables Compared				t-value	Probability
First	Mean	Second	Mean		
No Disability		One Disability			
Ability I	61.96	Ability I	58.30	9.46	0.01
Ability II	65.36	Ability II	61.16	10.39	0.01
Attitude I	24.89	Attitude I	22.82	11.87	0.01
Attitude II	25.36	Attitude II	23.39	12.31	0.01
No Disability		Two Disabilities			
Ability I	61.96	Ability I	53.39	15.44	0.01
Ability II	65.36	Ability II	56.70	14.22	0.01
Attitude I	24.89	Attitude I	20.91	24.31	0.01
Attitude II	25.36	Attitude II	22.27	13.04	0.01
One Disability		Three Disabilities			
Ability I	58.30	Ability I	53.00	8.15	0.01
Ability II	61.16	Ability II	54.50	9.13	0.01
Attitude I	22.82	Attitude I	20.80	8.31	0.01
Attitude II	23.39	Attitude II	21.70	8.10	0.01
One Disability		Two Disabilities			
Ability I	58.30	Ability I	53.39	12.96	0.01
Ability II	61.16	Ability II	56.70	3.23	0.01
Attitude I	22.82	Attitude I	20.91	10.73	0.01
Attitude II	23.39	Attitude II	22.27	6.71	0.01
Two Disabilities		Three Disabilities			
Ability I	53.39	Ability I	53.00	.37	N.S.
Ability II	56.70	Ability II	54.50	1.79	N.S.
Attitude I	20.91	Attitude I	20.80	1.84	N.S.
Attitude II	22.27	Attitude II	21.78	1.12	N.S.

Table 20. Significance of Difference Between Means Indicating Changes in Scores of Newly Blind Clients by Number of Disabilities Other than Blindness

Disability Category	Variables Compared				t-value	Probability
	First	Mean	Second	Mean		
No Disability	Ability I	61.96	Ability II	65.36	6.09	0.01
	Attitude I	24.89	Attitude II	25.36	1.96	N.S.
One Disability	Ability I	58.30	Ability II	61.16	10.21	0.01
	Attitude I	22.82	Attitude II	23.39	4.87	0.01
Two Disabilities	Ability I	53.39	Ability II	56.70	5.57	0.01
	Attitude I	20.91	Attitude II	22.27	5.39	0.01
Three Disabilities	Ability I	53.00	Ability II	54.50	.66	N.S.
	Attitude I	20.80	Attitude II	21.78	1.07	N.S.

Table 21. Significance of Difference Between Score Means for Newly Blind Clients by Kinds of Disability Other then Blindness

Variables Compared				t-value	Probability
First	Mean	Second	Mean		
Hearing Loss		Arthritis			
Ability I	53.67	Ability I	57.38	3.47	0.01
Ability II	57.13	Ability II	59.62	1.90	N.S.
Attitude I	20.87	Attitude I	23.81	5.92	0.01
Attitude II	22.79	Attitude II	23.06	.59	N.S.
Hearing Loss		Heart Condition			
Ability I	53.67	Ability I	57.39	3.38	0.01
Ability II	57.13	Ability II	58.43	.51	N.S.
Attitude I	20.87	Attitude II	22.35	3.33	0.01
Attitude II	22.79	Attitude II	22.83	.09	N.S.
Hearing Loss		Diabetes			
Ability I	53.67	Ability I	58.55	7.36	0.01
Ability II	57.13	Ability II	61.32	6.37	0.01
Attitude I	20.87	Attitude I	22.79	5.32	0.01
Attitude II	22.79	Attitude II	23.53	2.47	0.05
Arthritis		Heart Condition			
Ability I	57.38	Ability I	57.39	.01	N.S.
Ability II	59.62	Ability II	58.43	1.48	N.S.
Attitude I	23.81	Attitude I	22.35	3.37	0.01
Attitude II	23.06	Attitude II	22.83	.57	N.S.
Arthritis		Diabetes			
Ability I	57.38	Ability I	58.55	1.87	N.S.
Ability II	59.62	Ability II	61.23	2.41	0.05
Attitude I	23.81	Attitude I	22.79	3.34	0.01
Attitude II	23.06	Attitude II	23.53	1.70	N.S.
Heart Condition		Diabetes			
Ability I	57.39	Ability I	58.55	2.75	0.01
Ability II	58.43	Ability II	61.23	7.78	0.01
Attitude I	22.35	Attitude I	22.79	1.60	N.S.
Attitude II	22.83	Attitude II	23.53	2.62	0.05

Table 22. Significance of Difference Between Means Indicating Changes in Scores for Newly Blind Clients by Kinds of Disabilities Other than Blindness

Disability Category	Variables Compared				t-value	Probability
	First	Mean	Second	Mean		
Hearing Loss	Ability I	53.67	Ability II	57.13	2.75	0.05
	Attitude I	20.87	Attitude II	22.79	3.77	0.01
Arthritis	Ability I	57.38	Ability II	59.62	1.98	N.S.
	Attitude I	23.81	Attitude II	23.06	1.66	N.S.
Heart Condition	Ability I	57.39	Ability II	58.43	1.53	N.S.
	Attitude I	22.35	Attitude II	22.83	1.22	N.S.
Diabetes	Ability I	58.55	Ability II	61.32	6.18	0.01
	Attitude I	22.79	Attitude II	23.53	3.91	0.01
Stroke	Ability I	53.38	Ability II	55.23	1.05	N.S.
	Attitude I	21.62	Attitude II	21.08	.82	N.S.

Table 23. Significance of Difference Between Means Indicating Changes in Scores for Apartment Group and Blind-Over-Ten-Years Category

Population Category	Variables Compared				t-value	Probability
	First	Mean	Second	Mean		
Apartment Group	Ability I	58.43	Ability II	71.14	10.09	0.01
	Attitude I	23.86	Attitude II	26.29	2.75	0.01
Blind-over-10 Years Category	Ability I	62.73	Ability II	62.91	.09	N.S.
	Attitude I	24.82	Attitude II	23.55	.98	N.S.

APPENDIX III

BIOGRAPHICAL SKETCHES OF PROJECT PERSONNEL

HAROLD W. DRANE, M.S.S.W.

Harold W. Drane was born on May 29, 1925, in Tacoma, Washington. He completed his undergraduate studies with a B.A. in Psychology at the University of Puget Sound in Tacoma, Washington, in 1950. In 1952-53, he did graduate work in psychology at the University of Oregon. In 1956, he was awarded a Master of Science in Social Administration Degree by the School of Applied Social Science of Case Western Reserve University in Cleveland, Ohio.

Between 1950 and 1952, Mr. Drane was Chief Social Work Technician, Psychiatric Section, at the Valley Forge Army Hospital. In 1953-54, he served as case worker with the Department of Public Assistance, the State of Washington. From 1956 to 1959, he was Coordinator of Therapy in the Children's Unit of the Cleveland State Hospital. And between 1960 and 1962, he was Assistant Director of Social Service in the same hospital.

Since 1962, Mr. Drane has been with the Cleveland Society for the Blind as Director of Client Services and later as Associate Executive Director in charge of all rehabilitation services. He was the chief planner of the project, "Home Teaching of the Newly Blinded Geriatric Clients," from its earliest beginnings and developed the initial proposal, policies and instruments. He has served as Project Director from its first day in 1966 to its last day in 1969. He has recently accepted a position of Associate Director, Community Mental Health Center, Lansing, Michigan, with an appointment of Assistant Professor of Psychiatry at Michigan State University.

Mr. Drane is married and has two children. He is a member of numerous professional organizations, among them the National Rehabilitation Association, American Association of Workers for the Blind, and National Association of Social Workers.

GILES EDWARD GOBETZ, Ph. D.

Giles Edward Gobetz (or, in Slovenian, Edi Gobec), a naturalized American citizen originally from Slovenia, studied in Slovenia, Germany, Italy and the United States and has education and experience in linguistics, philosophy, psychiatric social work, and sociology. A former UN/IRO interpreter, hospital administrator and Resettlement Officer (in charge of emigration), he obtained his Ph. D. in Sociology from the Ohio State University in March, 1962. While working on his doctorate, he was employed as a Certified Class II Psychiatric Social Worker with the Ohio Department of Health. He later taught sociology, social psychology and criminology at the Cuyahoga Community College, the Ohio State University and the University of Maryland. Prior to his appointment as Research Consultant with the Cleveland Society for the Blind, he was Senior Research Associate with the Cleveland Community Action for Youth, a demonstration program in the prevention of juvenile delinquency through youth development, where one of his youth-development proposals resulted in the U.S. Congress House Joint Resolution 24.

A past editor of *Akademik* and *Slovenski Visokošolski Zbornik* and author of *Love Moves Mountains*, *Scouting and the Disadvantaged Girl*, *Reaching the Unreached in Hough*, *From Carniola to Carnegie Hall*, *Learning Mobility in Blind Children and the Geriatric Blind*, and of numerous articles in books, journals and encyclopedias, Dr. Gobetz is also Director of the Slovenian Research Center of America, Executive Secretary of EURAM Books, a member of several professional organizations, and an honorary member of Delta Tau Kappa, the International Social Science Honor Society. President Richard Nixon sought his advice with regard to appointments in his Administration.

Dr. Gobetz is currently Associate Professor of Sociology and Anthropology at Kent State University and is working on a college text in juvenile delinquency and on a book about Slovenian immigrants in various countries. He is 43 years old, married and father of two children.

ELEANOR L. UNDERWOOD, B.S.

Mrs. Underwood was born on December 11, 1902 in Chicago, Illinois. In 1924, she graduated with a B.S. in Education (Major in Home Economics) from Miami University, Oxford, Ohio, and then taught for a year at Kent Roosevelt High School. Between 1925 and 1927, she did graduate study at the School of Applied Social Science of Western Reserve University in Cleveland, Ohio.

She married in 1926, brought up three children, and became a widow in 1959. In addition to her role of housewife and mother during her married life, Mrs. Underwood was very active in volunteer activities connected with education, scouting, community relations, church work and hospital services. She also completed a six-month course for a volunteer aide in occupational therapy and, between 1945 and 1950, donated about 2500 hours in this area to various chronic and veterans hospitals. She is a past President of her Sorority Alumnae and of the Junior Board of the Women's Hospital; past Vice President of the PTA, and a past board member and Vice President of the College Club of Cleveland.

In 1956, Mrs. Underwood came to the Cleveland Society for the Blind as an occupational therapy crafts instructor. Later, this position was enlarged to include home economics area and instruction in Activities of Daily Living. In this capacity, Mrs. Underwood worked with blind people of all ages, including several special children's programs, the diabetic clinic for education and information, and a home teacher workshop program.

Mrs. Underwood also supervised this agency's kitchen personnel and assisted in meal planning and in the organization of special events. She has given instruction in sewing techniques and related activities for rehabilitation clients and also for homebound clients in a special home industries program. She has also done pre-evaluation of clients on power sewing machines.

All these varied activities contributed insight toward the special problems and needs of the geriatric blind clients. Since August, 1966, Mrs. Underwood served as this project's Principal Investigator. Widely traveled and a member of several prestigeful organizations and clubs, Mrs. Underwood currently lives in Mentor, Ohio.

JUNE JENKINS, M.Ed.

Miss June Jenkins was born May 11, 1936, in Homestead, Pennsylvania. She received her elementary and secondary education at the Western Pennsylvania School for Blind Children in Pittsburgh. She lived at the school during the week and was able to come home for weekends. In this way, she was able to participate in scouting and other social activities at the school and still maintain a close relationship with her family. She was graduated from high school in June, 1956.

Miss Jenkins received her A.B. Degree from Grove City College, with a major in sociology, in June, 1961. During her college career, she participated in various activities, including the college choir and two national honorary societies, Cwens, a National Sophomore women's honorary, and Pi Gamma Mu, a national social science honorary.

Following graduation from college, Miss Jenkins was employed as a special education teacher by the Altoona school district from September, 1961 until June, 1964. Her work consisted of teaching academic subjects to two teen-age blind students and the teaching of braille and typewriting to blind adults.

Miss Jenkins attended Western Michigan University in Kalamazoo, Michigan, from September, 1964 until December, 1965. She graduated with a Master's Degree in Special Education, Program for Training Home Teachers of the Adult Blind, and accepted a position as a Home Teacher at the Cleveland Society for the Blind in January, 1966. She left the Cleveland demonstration project in home teaching at the end of December, 1968, to accept a position at the Veterans Hospital in Palo Alto, California.

Miss Jenkins enjoys several hobbies, including reading, music, knitting, swimming and attending movies and plays.

SUZANNE JOHNSON, M.Ed.

Miss Johnson was born on December 30, 1940, in Center, Texas. Glaucoma developed in one eye when she was one year old. The same condition occurred in the other eye one year later. She moved to Austin, Texas, at the age of six. At that time, she began attending the school for the blind. At the end of her sophomore year, she returned to East Texas and attended public school the last two years. After graduation, Miss Johnson attended Stephen F. Austin State College in Nacogdoches, Texas, for three years. In 1966, she received her Master's Degree in Special Education, Program for Training Home Teachers of the Adult Blind, from Western Michigan University in Kalamazoo, Michigan. She began working at the Cleveland Sight Center in January, 1967, and left the Cleveland demonstration project in home teaching in October, 1968, to become a home teacher in Kalamazoo, Michigan.

Miss Johnson is single and enjoys bowling, swimming and water sports. She is a football and baseball fan and likes operas, concerts and, occasionally, movies.

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